North West
LOCAL HEALTH INTEGRATION NETWORK

Annual Service Plan
2008/09

Final Report

May 2008

Ontario

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1.0 Introduction

Based on the premise that local communities best understand their health care needs and priorities, the North West Local Health Integration Network (LHIN) is mandated to plan, coordinate, integrate and fund the delivery of health services at the local level.

The Annual Service Plan (ASP) is a multi-year plan outlining the North West LHIN's implementation of its *Integrated Health Services Plan* (IHSP). The IHSP, a three-year plan identifying priorities and accompanying action plans for the Northwest, was developed following extensive community engagement and data analysis.

High level detail on specific plans and projects to advance the following priorities outlined in the IHSP are included in the ASP:

- Access to Care
  - Access to Primary Health Care
  - Chronic Disease Prevention and Management
  - Access to Specialty Care
  - Access to Mental Health and Addiction Services
- Seniors' Services
- Integration of Services along the Continuum of Care
- Engagement with Aboriginal People
- Ensuring French Language Services
- Integration of e-Health
- Regional Health Human Resources Plan

The Ministry-LHIN Accountability Agreement (MLAA) requires LHINs, through their ASPs, to provide the basis of support for any regional transformation objectives and associated funding realignments, if required. The ASP also informs the Ministry of Health and Long-Term Care's (MOHLTC) Results-Based Planning process which establishes the Ministry priorities and annual appropriations.

Sharing the information in the ASPs allows the LHINs and the government to work together to reduce duplication, enhance co-ordination and improve health care access across the province. It will also assist the public to understand how the North West LHIN is planning to address the needs of the community.

North West LHIN Mission, Vision and Strategic Directions

The Board of Directors has developed the following Mission, Vision and Strategic Directions for the North West LHIN.

Mission

Develop an innovative, sustainable and efficient health system in service to the health and wellness of the people of the North West LHIN.

Vision

Healthier people, a strong health system – our future.

Strategic Directions

- Building a sustainable, integrated health system.
- Fostering a spirit of engagement and collaboration.
- Creating a new, system-wide culture of accountability and funding.
- Fostering innovation, research and learning.
- Developing a quality work environment that results in the North West LHIN as a workplace of choice.

Relationship Between North West LHIN and Ministry Priorities

The following table illustrates the relationship between priorities outlined in the North West LHIN's *Integrated Health Services Plan* and the priorities of the Ministry of Health and Long-Term Care. The five IHSP priorities outlined below the table enable provincial and local priorities.

North West LHIN Priority	**Ministry Priority**		
	Family Health Care	Emergency Department Wait Times	Alternate Level of Care
Primary Health Care			
Specialty Services			
Chronic Disease Prevention and Management			
Mental Health and Addictions Services			
Seniors' Services			
Enabling Priorities			
Integration along the Continuum of Care →			
Engagement with Aboriginal People →			
Ensuring French Language Services →			
Integration of e-Health →			
Health Human Resources →			

2.0 Northwestern Ontario: The Context for Planning (Environmental Scan)

2.1 Population Characteristics and Geography

Large geographic area

The North West LHIN covers a very large geographic area (458,010 km^2)—47% of the province of Ontario—including the Districts of Rainy River and Thunder Bay and most of the Kenora District. Providing health care services in such a large geographic area is a challenge.

Low population density

The North West LHIN is the least densely populated LHIN in the province. The population density at only 0.5 people per square kilometre is much lower than the Ontario average of 12.6 people per square kilometre. Overall, the LHINs in Ontario are involved in planning for services for populations with an average density of 600 people per square kilometre.

Declining population

The North West LHIN is home to 235,046 (2006)[1] people, or 2.0% of the population of Ontario. The population of the Northwest decreased by 1.2% between 2001 and 2006, markedly different from the population of Ontario as a whole which increased by 6.6% during this period.

Socioeconomic status

The Northwest had the highest unemployment rate (8.3%) in the 2006 census. This was considerably higher than the provincial rate (6.4%). These trends are expected to continue as resource-based industry is in decline across the region. The North West LHIN is currently engaged in a research project with the Centre for Rural and Northern Health Research at Lakehead University to determine the population health impact of the decline in the forestry industry.

The Northwest has a higher proportion of residents with lower academic achievement than the rest of the province. Residents of the Northwest have a higher proportion with less than grade nine education (10.6% vs. 8.7%), less than high school graduation certificate (32.0% vs. 25.7%) and the lowest proportion having completed post-secondary education (43.9% vs. 48.7%).

Population is aging at a fast rate

The population of the Northwest, compared to the provincial population, has a slightly higher proportion of people 65 years or older. The lack of new immigrants, slow population growth and continued youth out-migration contribute to the older age of Northwestern Ontario's population. Youth out-migration is now at its highest level. From 1996-2001, the population in Northwestern

[1] 2006 Census of Canada data.

Ontario aged 55 years and over increased by 5.1%. During the same period, the population of youth dropped significantly (-7.2%) and the population of people aged 25-54 also declined (-3.4%). From 2008 to 2017, our senior population is projected to grow from 13.9% of the population to 17.4% of the population, an increase of 3.5%. Ontario, in comparison, will increase from 13.3% to 15.7%, an increase of only 2.5%. The working population, from the ages of 25-54, will decrease from 42.1% to 38.2%, compared to Ontario declining from 44.6% to 42.6%. This is the age group most involved with providing unpaid care to our seniors.

The aging of the population will require changes in health care services as Northern Ontario has historically had a younger population compared to the provincial average. In addition, there will be challenges related to informal and formal caregiving as fewer people are available for these roles in younger cohorts.[2]

Numerous small towns and First Nations communities

The North West LHIN has many small towns and First Nations communities that are spread throughout rural and remote areas. Planning, delivering and accessing health services in these areas are often difficult due to the remote location of these communities. For example, many First Nations communities are not accessible by road year-round. During much of the year, people in the Northwest are exposed to hazardous weather, poor road conditions and travel delays that make the long distance travel required to access health care services a significant challenge.

The issue of non-urgent transfers by land ambulance is a significant concern for providers and clients in Northwestern Ontario. The vast geography of the region results in a large number of these transfers. At the present time, providers are coming together to discuss strategies for dealing with this situation; they report that the need to cover the costs of non-urgent transfers poses financial challenges.

Large Aboriginal population

The North West LHIN has the highest percentage of Aboriginal people in the province (13.9%); this is substantially higher than the provincial average of 1.7%. The population of Aboriginal people may be even larger since they are under-counted in the Census data. This under-representation of Aboriginal people impacts many of the routinely published indicators of health status. Improvements to the quality of data on Aboriginal people are required. Canadian studies on Aboriginal health have consistently shown that Aboriginal people have reduced life expectancy and lower health status compared to the general Canadian population. The poor health and social conditions result in earlier deaths among Aboriginal populations. This fact, along with a higher birth rate, results in a much younger Aboriginal population than the non-Aboriginal population.[3]

Health status

The life expectancy among males and females in the Northwest is the lowest in the province. The Northwest also has the highest age-standardized mortality rate in Ontario and the highest percentage of deaths before age 65. In the Northwest, 24.9% of deaths occur before the age of 65, and 44.5% occur before the age of 75 (Ontario percentages are 21.3% and 41.2%,

[2] Youth Out-Migration in Northern Ontario – 2001 Census Research Paper Series: Report #2, Training.

[3] LHIN Population Health Data, Prepared by MOHLTC Health Systems Intelligence Project (HSIP), July 1, 2005.

respectively). The Potential Years of Life Lost (PYLL) is also the highest in Ontario. The infant mortality rate in the Northwest (5.1/1000 of live births) is slightly lower than the provincial rate (5.4/1,000 of live births). Residents of the Northwest report their health as "Excellent" or "Very Good" at rates that are significantly lower (51.0%) than the province as a whole (57.4%). A significant proportion of residents (29.4%, compared to 24.6% provincially) report being limited in their activities because of a physical or mental condition or health problem which lasted or is expected to last longer than six months.

Residents of Northwestern Ontario smoke more and consume higher quantities of alcohol than the provincial average. Rates of obesity are also higher than elsewhere in the province. The earlier onset of chronic illness in the North West LHIN is linked to lifestyle choices, hence the importance of an effective chronic disease prevention and management strategy.[4]

2.2 Engaging Our Communities

Community engagement continues to be a priority for the North West LHIN, providing information that is used when identifying health system priorities, opportunities to develop new partnerships and work together, and innovations to overcome challenges.

In 2007/08, the North West LHIN hosted over 150 sessions (including forums, roundtable discussions, meetings, workshops and training) for over 2,500 participants. Given the interconnectedness of our health system, stakeholders include health service providers; community members and leaders; educators; municipal, provincial and federal government officials; other ministries and jurisdictions; and other funding agencies. Sessions focused on issues such as advancing the priorities outlined in the North West LHIN's IHSP, Hospital Service Accountability Agreements, Aging at Home, the Centre of Excellence for Integrated Seniors' Services and updates on LHIN activities. The LHIN continues to share information broadly through our newsletter, *LHINkages*, and website.

The North West LHIN continues to evaluate sessions using evaluation forms and providing opportunities for feedback, and to-date the majority of feedback has been very positive. Where there are suggestions for improvement (often environmental), we continue to modify and improve our community engagement activities as we proceed. Working with Dr. Julia Abelson, a professor from McMaster University, the North West LHIN will develop evaluation tools for monitoring and reporting the effectiveness of its community engagement activities.

To increase the reach of our engagement, the North West LHIN continues to be innovative in its delivery and collection of information. In the winter of 2007, we hosted our first photography contest *Show Us Your Vision*, resulting in over 500 local images to be used in our many publications and presentations and approximately 50 individuals (mostly community members) requesting ongoing information from the LHIN. Following *An Opportunity for Real Change: Advancing Health System Transformation in the North West LHIN*, a forum with 300 participants from across the region, full presentations have been posted on our website using YouTube, allowing for easy viewing. A videoconference speaker series, featuring experts in a variety of areas, will be launched in June 2008 and will increase access to the discussions and materials

[4] LHIN Population Health Data, Prepared by MOHLTC Health Systems Intelligence Project (HSIP), July 1, 2005.

arising from the session, with availability to attend from videoconference sites across the region and beyond, and with sessions archived on the North West LHIN website.

The North West LHIN continues to partner with individuals, groups and organizations within and outside of Northwestern Ontario. The North West LHIN has initiated a number of Advisory Teams, Committees and Work Groups to advance the priority areas identified in the IHSP. We continue to partner with health service providers in a number of ways, including those who are not funded by the LHIN, such as public health units, physicians and provincial programs.

The North West LHIN will continue to engage stakeholders from across the LHIN in planning, priority-setting and decision-making processes and work with partners in other LHINs and jurisdictions to advance health system transformation in the Northwest.

2.3 Issues Affecting the Utilization of Health Services

2.3.1 Access to Care

Access to Primary Health Care

Difficulty in gaining access to primary care physician services is a consistent theme which emerges in both urban and rural areas of the North West LHIN during community engagement. Poor access to family health care was cited as a barrier to providing seamless care along the continuum.

Though the number of family physicians per capita in the Northwest is higher than the provincial average, there are significant access issues. Due to the significant burden of illness and widely dispersed population, the Northwest requires a larger supply of providers than would be the case in more urban areas. Primary care physicians may have to travel to remote communities and the travel time reduces their clinical hours. For residents living in remote areas and First Nations communities, the need to travel to obtain primary care services also impedes access to needed health services.

The introduction of Family Health Teams (FHTs), wherein health professionals are utilized to their full scope of practice, may alleviate some of the current pressure for access to family health care. In addition, the use of mobile units further improves access to primary care. The NorWest Community Health Centres (CHC) offer primary health care services for clients throughout some parts of the Thunder Bay District via a mobile van unit. Eye care and breast screening continue to be offered in this innovative and effective way.

Residents of the Northwest report the lowest rates in the province for access to a medical doctor (84.5%) and consultation with a medical doctor (77.1%). Only Thunder Bay residents are able to receive more than 90% of their primary care physician services in their own sub-area. There is a general perception, however, that many residents of Thunder Bay do not have access to a primary care physician.

The Northwest has high rates of inpatient and emergency department (ED) care due to challenges in accessing family health care. Enhancing access to primary health care would lead to improved continuity of care for patients and reduce both ED visits and inpatient care. The North West LHIN ED Lead provides an important link to the region related to this area of practice.[5] Pursuing Nurse Practitioner-led clinics will be an opportunity to promote access to primary care in the region.

[5] CIHI NACRS Ontario data, 2004/05, CIHI/Hay Benchmarking Study WRHA data.

Access to Chronic Disease Prevention and Management (CDPM)

Currently, the expected lifespan for both men and women in the North West LHIN is the lowest in the province. Rates of obesity, smoking and alcohol consumption are higher than in other areas of the province. As a result, Northwestern Ontario residents experience high rates of chronic disease. More specifically, diabetes, arthritis/rheumatism, hypertension, asthma and heart disease are reported at rates that exceed provincial averages. The prevalence of diabetes in the Aboriginal population is of particular concern.

The CDPM strategy for the North West LHIN is guided by the Chronic Disease Prevention and Management CDPM framework recently adopted by the Ministry of Health and Long-Term Care. Built on the CDPM Model, the framework identifies the evidence-based attributes of a high functioning health system. Capacity for change amongst health service providers and consumers must be further advanced to ensure there is system readiness for the transformation required. The North West LHIN has focused efforts in this area, providing numerous knowledge transfer opportunities between experts and health service providers.

To support uptake of evidence-based change to improve CDPM, several innovative proposals were funded through the 2007/08 Urgent Priorities Fund in the Northwest. These included community exercise programs, the development of self-management materials in interprofessional practices and improved access to screening through telemedicine for remote communities.

Support for client self-management is another key component in moving forward with a CDPM strategy for the North West LHIN. Given the challenges in accessing primary care in the Northwest, this component of the framework is particularly relevant. As clients have increased confidence and capacity to manage their chronic diseases independently, there will be fewer acute exacerbations. To support improved self-management, 28 health service providers from throughout the region participated in Stanford Self Management training, becoming Master Trainers in a program coordinated by the North West LHIN in March, 2008. Several additional training sessions were also provided for health care workers in the region.

Prevention programs are an essential component of improved chronic disease prevention and management. The North West LHIN has partnered with regional public health units to offer capacity building sessions. Funding has also been provided for community exercise programs, serving clients with chronic diseases. These programs support a growing awareness of the importance of tertiary prevention.

e-Health is an important enabler for effective chronic disease prevention and management. In collaboration with the North East LHIN, strategies for advancing e-Health to support improved CDPM are being planned.

To achieve the vision outlined in CDPM framework, it will be necessary for significant health system redesign to take place. To support that transition, improvements in e-Health, client self-management and access to primary care are considered essential first steps.

The North West LHIN CDPM Advisory Team is currently engaged in action planning to advance implementation of the CDPM framework. Given the magnitude of change required for full implementation, it is expected that this work will be long-term.

Access to Specialty Care

In order to access specialty care, patients in rural areas must travel long distances to tertiary centres such as Thunder Bay, Winnipeg or beyond. Specialty groups often cited in short supply during community engagement include psychiatry, child and youth mental health programs, dermatology, supportive dialysis and cardiac care. During community engagement, consumers and health service providers reported poor coordination of specialty and related supporting services.

The Visiting Specialist Program provides access to specialty care in under-serviced regional communities. Clinicians make scheduled periodic visits offering specialty services such as orthopaedic surgery and oncology care throughout the region. The Visiting Specialist Program allows people to receive care close to home, which eliminates the need for travel and promotes more rapid recovery times.

High satisfaction was reported for services that are provided closer to home. Access to specialty services is enhanced through the use of telemedicine and there is potential to expand this modality further.

Several new initiatives in the planning or early implementation stages will also create improved access to specialty services. The provincial Wait Time Strategy has resulted in improved access to hip and knee replacement surgery, cataract surgery, cardiac surgery, cancer surgery and diagnostic services. The communities of Dryden and Fort Frances have each received approval to acquire and operate CT scanners and are planning to implement this technology in their communities. These services will be aligned with Thunder Bay Regional Health Sciences Centre to form a regional diagnostic service. Sioux Lookout has also applied for approval to acquire a CT scanner. Cataract surgery and colonoscopy services have been expanded in Marathon. TBRHSC recently announced the establishment of a Total Joint Centre and a stand-alone angioplasty service.

Access to Mental Health and Addictions Services

i. Addictions

The population of clients living with addictions in the Northwest is older than the provincial average, with only 28% under the age of 35 (compared to 42% for Ontario), and 25% over the age of 55 (compared to 10% for Ontario). Northwest residents made up 10% of the total Ontario substance abuse population, yet only 2% of Ontario's population resides in this area. It is reported that residents of the Northwest have significant challenges in accessing addictions services. More than half of the clients requiring services are unemployed (and looking for work) or their employment status is unknown. The declining resource-based economy of Northwestern Ontario makes it increasingly challenging to find work.

Clients often have to leave their communities to access specialized treatment. Outside of the larger communities (Thunder Bay and Kenora), there are few specialized addiction treatment centres, detoxification options, withdrawal management programs or transitional supports. People living with addictions are reported to have difficulty with medication management due to a shortage of family physicians in some communities in the Northwest. Providers also report that people are unable to have their prescriptions filled as employment benefits run out following lay-offs and unemployment.

ii. Mental Health Services

Crisis mental health services were identified as a particular challenge in many Northwestern Ontario communities. Most of the crisis services are found in Thunder Bay and Kenora, and residents from outside these cities reported reliance on telephone access to support psychiatric care in the local ED. Telepsychiatry services have been introduced and are expanding in the region.

Consumers and providers reported that services available are insufficient, with long wait times that do not support the needs of patients in crisis. It has been suggested that the limited access to these services causes 'treatable' conditions to escalate into long-term medical and social problems. Access issues were reported to be especially problematic for psychogeriatric services, transitional or supportive housing, walk-in mental health and addiction services, programs for those requiring more than 60 days of treatment and stabilization units/beds for mental health crisis.

A consortium of regional mental health and addictions providers, the Northwestern Ontario Mental Health and Addictions Services Network is working with consultants Dr. Kenneth Minkoff and Dr. Christie Cline to improve care across the continuum for clients with concurrent disorders. This work has the potential to improve access to mental health and addictions services and support system integration.

St. Joseph's Care Group (SJCG) has moved its community mental health services off the Lakehead Psychiatric Hospital site to a community location. SJCG has also initiated a public education plan with staff dedicated for this purpose. The Care Group will work with agencies across the Northwest, focusing on businesses and schools to increase awareness regarding mental health reform and to decrease the stigma surrounding mental illness.

A shared mental health care service has been established in the City of Thunder Bay. This model of service delivery supports and enhances the role of the family practice physician, provides quick access to psychiatric consultation, promotes dialogue between health care workers and enables the referral of patients to suitable service for ongoing care.

Sixty-four specialized behavioural beds were announced as part of the Centre of Excellence for Integrated Seniors' Services project (see below for full details). These beds will be an important resource for the entire Northwest region, supporting the growing number of people with dementia with specialized services in a safe and therapeutic environment.

The North West LHIN's Mental Health and Addictions Advisory Team has been struck and has commenced meeting.

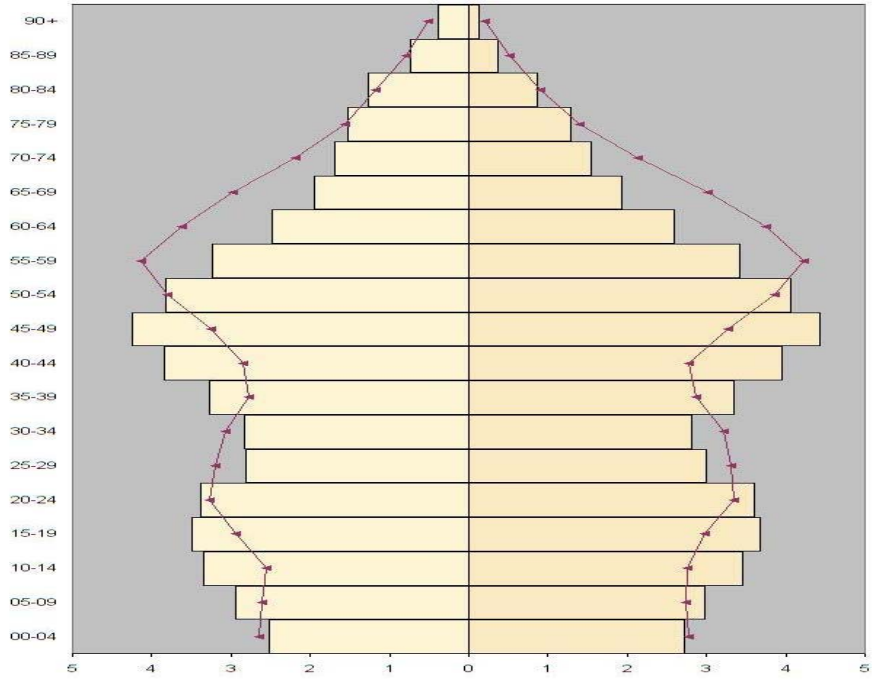
2.3.2 Seniors' Services

Compared to the provincial population, the Northwest has a higher proportion of people 65 years or older. The lack of new immigrants, slow population growth and continued youth out-migration contribute to the older age of Northwestern Ontario's population. Youth out-migration is now at its highest level. From 1996-2001, the population in Northwestern Ontario aged 55

years and over increased by 5.1%. During the same period, the population of youth dropped significantly (-7.2%) and the population of people aged 25-54 also declined (-3.4%). This demographic profile suggests that there will be future challenges related to formal and informal care giving for seniors, as fewer people will be available for these roles in younger cohorts. Furthermore, this youth out-migration represents a loss of potential formal care providers. Securing skilled caregivers is increasingly a challenge for many communities and seniors in the Northwest.

The following exhibit shows the population structure of the North West LHIN. The purple line denotes the population projection for 2017, which shows that there will significant shift towards an older population in the next ten years. While there may be a slight increase in population in the 25-34 year age group, there is predicted to be a large decrease in the percentage of population that is in the 35-54 year age group.

Exhibit 2.0 Projected Age-Sex Population Distribution (2007 and 2017) Source: 2001 Census



The population of the North West LHIN is decreasing, with an expected 4.4% decline expected by the year 2031. The population of seniors will continue to grow over this time period by 77.4% in the 65-69 year age group between 2007 and 2031; 105.4% in the 70 – 74 year age group and 80.3% in the 75 – 79 year age group. Significant growth is also projected for people 80 years of age and older. Projections indicate that by 2031 the percentage of the North West LHIN population over the age of 65 will be 25.6%. (See Table 1 for details.)

Table 1. Population Project Comparison 2007 and 2031 with Percentage Increase

Age	2007	2031	% Increase
65-69	9,100	16,145	77.4%
70-74	7,624	15,656	105.4%
75-79	6,633	11,959	80.3%
80-84	5,028	8,176	62.6%
85-89	2,599	3,817	46.9%
90+	1,240	1,805	45.6%
Total Pop	235,167	224,786	-4.4%

In addition to the declining population, the Northwest also has the lowest life expectancy among males and females in the province and Northwest residents report higher than average rates of chronic disease. Arthritis afflicts approximately 17.2% of the population of Ontario, while it is reported in approximately 21.4% of the population in the Northwest. Heart disease is reported as 16.1% in the 65-74 age group in Ontario, while affecting 26.7% of the same age group in the Northwest. With a high burden of chronic disease, it is expected that there will be challenges to support seniors aging at home in the North West LHIN.

Aboriginal people, who make up a large and growing proportion of the population, are developing chronic diseases earlier in life. In addition, this population has a high incidence of diabetes. Many of the support programs and services that are common in larger communities such as community respite, transportation, supportive housing and Alzheimer day programs do not exist in many of the northern/rural communities. Admission to a nursing home is often the only option for seniors, who might be better supported to age at home. This has significant implications for requirements for long-term care services and the future health care needs of the seniors.

Access to services is an ongoing challenge in the North West LHIN. Many seniors outside of Thunder Bay must travel great distances to access specialty services. As road conditions are less than optimal for several months of the year and the drive to services is often long and isolated, many seniors choose not to travel.

In addition, services for seniors across the continuum of care are not consistently available across the North West LHIN. Cultural and linguistic requirements (e.g. for the Aboriginal and Francophone populations) may present a barrier for seniors accessing services. As well, there is an identified and documented shortage of home support services and supportive housing for seniors across the Northwest. Several reports[6][7][8] have suggested that appropriate investments

[6] 2006 Population Estimates, Ontario Ministry of Finance, accessed through PHPDB.

. "A Study of Alternate Care in the City of Thunder Bay", Northwestern Ontario District Health Council, 2004.

[7] "Integrated Service Plan for Northwestern Ontario", Report of the Special Advisor, Tom Closson, June 2005.

[8] "A Study of Alternate Care in the City of Thunder Bay", Northwestern Ontario District Health Council, 2004.

in community supports and supportive housing could actually reduce the need for long-term care home beds and allow seniors to remain in their homes for longer periods.

The use of technology has helped to improve access to services. A number of specialists use the Ontario Telemedicine Network (OTN) to conduct appointments with their patients. There is only one geriatrician to serve this vast region, and through the use of telemedicine, his capacity to serve clients in the region is greatly enhanced. Many other specialists also use this technology, which increases access and reduces the need for seniors to travel to access services. An innovative cardiac rehabilitation program is offered to seniors in small communities in Northwestern Ontario through telemedicine.

The preferred option for seniors in the North West LHIN is to "age at home" for as long as possible. As there is an identified shortage of home support services and supportive housing throughout the North West LHIN, Aging at Home Strategy and other initiatives will be centered on maintaining the elderly in the community for as long as possible.

In January 2007, the City of Thunder Bay announced its decision to return 300 municipally run long-term care home beds to the province effective January, 2009. As a result of the pending closures, the North West LHIN, MOHLTC and not-for-profit provider St. Joseph's Care Group (SJCG) are planning a Centre of Excellence for Integrated Seniors' Services (CEISS). Components of the plan include: services for additional Community Care Access Centre (CCAC) and Community Support Service (CSS) clients, enhancements to existing supportive housing, new supportive housing and new long-term care home beds with specialized care for elderly clients with responsive behaviours. The services for additional CCAC and CSS clients, as well as the enhancements to existing supportive housing, will be phased in over the years 2008/09 and 2009/10. The new supporting housing units and long-term care home beds will be in place in 2010/11.

This innovative strategy incorporates best practices, facilitates aging at home and is consistent with recommendations in numerous recent health studies including the North West LHIN's *Integrated Health Services Plan* (2006), *Integrated Service Plan for Northwestern Ontario, Report of the Special Advisor, Tom Closson,* June 2005 and *Supportive Housing: A Needs Assessment* (2004) completed by the former Northwestern Ontario District Health Council. Additional funding will be required to cover the cost of project management for this extensive undertaking.

A key predictor of admission to residential long-term care is a diagnosis of dementia. The number of residents in Northwestern Ontario with dementia is projected to increase substantially as the population ages. The responsive behaviours associated with dementia require specialized supports for residents. A 64 bed unit for clients with responsive behaviours is a key component in the development of the CEISS and this program will function as a regional resource for Northwestern Ontario health service providers.

A study is being conducted by a multidisciplinary team of established researchers at the University of Toronto, in collaboration with the North West LHIN and North West CCAC to answer the question, "What proportion of individuals currently on the long-term care (LTC) home wait list in Northwestern Ontario could be maintained at home if given access to integrated community-based care packages?". It adapts a Balance of Care (BoC) approach pioneered by researchers in the UK to assess the service mix that would be required to sustain individuals currently at risk of losing their independence in the community.

The need for enhanced long-term care services, including supportive housing, home care, and long-term care home beds was identified as an important issue at every community engagement session in the North West LHIN. In many regional communities there is no supportive housing and very limited access to home care services creating system pressures as the population ages. The “Case Mix Measure” (representing the relative acuity of the residents) for long-term care home residents is the lowest in the province, suggesting that a significant number of residents might manage with additional supports in the community if this option was available.

Access to long-term care home beds is a challenge in many communities, creating pressure for some residents to accept residential placements outside of their home communities. This results in separation of individuals from family and friends, leading to a decline in health and potentially a greater need for health services. The average wait time for placement in the long-term care home of first choice is 140 days in the Northwest, compared with an average of 93 days for the province. As seniors’ services are realigned to include greater support for aging at home, it is anticipated that the demand for placement in long-term care homes will be reduced.

Planning for seniors’ services in regional communities is an important next step. There are perceived gaps in seniors’ services throughout the North West LHIN and several regional communities have identified the need for additional long-term care home beds, supportive housing and community services. The North West LHIN has issued a Call for Proposals for “Innovative Alternatives that Promote Aging at Home”. Proposals must support the priorities as outlined in the North West LHIN’s Aging at Home Service Plan, including strategies that will reduce ALC.

2.3.3 Integration of Services along the Continuum of Care

Although coordination, communication and cooperation among health service providers are deemed to be strengths in the North West LHIN, there is potential for improvement. Enhanced sharing of information amongst providers regarding roles and mandates may increase cooperation among providers and support an improved “systems approach” to the delivery of health care services in the Northwest. Opportunities exist to enhance integration of services and community based services in smaller more rural communities across the Northwest region. The implementation of an electronic health record is an important enabler in the integration of client care.

Increasing numbers of alternate level of care (ALC) clients in the acute care and complex continuing care and rehabilitation settings is an issue in the North West LHIN. The most significant impact is felt at Thunder Bay Regional Health Sciences Centre (TBRHSC) where reduced access to inpatient beds limits the hospital’s ability to function as a tertiary centre for the Northwest region. Over the past six months TBRHSC has frequently experienced “Code Gridlock”. This is a term used by the hospital to describe the inability to move admitted patients from the emergency department to inpatient beds as a result of the number of clients deemed as ALC. The lack of available inpatient beds at TBRHSC results in cancelled elective surgeries, reducing the ability of the system to complete targeted wait time surgeries and causing system wide backlogs.

Several important initiatives have been implemented to reduce ALC pressures:

A Geriatric Emergency Management (GEM) Program initiative, funded under the Emergency Department Action Plan, was established at TBRHSC to implement systems and business process improvements designed to improve care for the elderly patient.

In addition, funding approved for TBRHSC under the Emergency Department Support Fund was used to create a regional ED network of providers and two pilot patient navigators for the ED. One navigator focused specifically on clients from regional communities (outside of Thunder Bay) and the other focused on Thunder Bay clients, with process redesign an outcome of the initiative. Over the upcoming year, these initiatives will be evaluated to measure the impact on utilization patterns, patient satisfaction, quality of care and emergency overcrowding.

The "Flo" Collaborative initiative was implemented in partnership between TBRHSC, St. Joseph's Care Group, the North West CCAC and the North West LHIN. The goal of the "Flo" Collaborative is to address the flow of patients through the system while expediting discharge to the appropriate setting in a timely manner.

Crisis 1A was implemented for a one month period of time at TBRHSC to assist with expediting placement to long-term care and funding for an additional 5 interim long-term care beds was identified as a short term solution to the high ALC numbers within the acute care setting. Further work is in progress with the goal to identify short term, medium term and longer term solutions to the ALC pressures while improving access to ED services.

In 2007/08, funding under the Emergency Department Action Plan's "Implementing More Care in the Community" initiative resulted in service enhancements for various CSS agencies and a supportive housing program, in order to maintain seniors in the community. In addition, new resources will be provided over 2008/09 and 2009/10 to CCAC, CSS and supportive housing service providers under the CEISS initiative, in order to ensure seniors are cared for in the appropriate setting as part of the transition plan for the establishment of the new LTC beds and supportive housing units.

In 2007/08, a significant portion of the Urgent Priority Funds was invested on a one-time basis in seniors'-related initiatives. Many of these initiatives identified a potential impact on reducing ALC pressures. Over the next three years, Urgent Priorities Funds will be targeted to initiatives that will result in improved access to ER services and reduced ALC pressures within the acute care setting. Resources will be provided to support better management of chronic diseases, promote more coordinated care in the community and in non-emergency settings, while at the same time reducing the number of visits to ED.

2.3.4 Engagement with Aboriginal People

There is a need for improvement of Aboriginal health status and health services in Aboriginal communities. Canadian studies have consistently shown that the Aboriginal populations have reduced life expectancy and poor health status compared to the general Canadian population. The remote location of many northern communities poses a significant problem in accessing services. Most Aboriginal communities have limited services and residents are forced to travel to access the care they need. In addition, some communities do not have all-season access

roads which poses challenges in accessing health services. Along with geographic barriers, there are also language and cultural barriers to accessing services. The lack of culturally sensitive, linguistically accessible services in the North West LHIN poses challenges to both patients and providers of care. Participants of two Aboriginal focus groups identified a need for services available in Ojibway, Cree, Oji-Cree and dialects that include options for traditional healing and medicines.

Over the past year, the North West LHIN has met with Aboriginal individuals and communities including First Nation leaders. For example, at the fall 2007 OHA Aboriginal Forum the North West LHIN hosted a meet and greet session for conference participants and in Winter 2008, Aboriginal Health Directors met with the North West LHIN staff to provide input into our Aging at Home Strategy.

In addition, the North West LHIN hosted its first Aboriginal Health Forum, in March 2008 to address three priorities: relationship building; working together; and communication. Over 200 participants attended this two day session involving participation from 34 communities and 66 organizations.

The North West LHIN has also participated in two consultation sessions regarding the development of a regulation for Local Aboriginal Health Planning Entities (LAHPEs). The North West LHIN is committed to working with the LAHPE, once established, to address health needs and priorities.

A recent innovation that may serve as a template for future initiatives is a film produced by the Northwestern Ontario Regional Stroke Network entitled *Heartbeat of the Anishnawbe Nation.* The film has been positively received as a culturally sensitive health teaching tool for Aboriginal people.

2.3.5 Ensuring French Language Services

The proportion of Francophone residents in the North West LHIN is similar to the province as a whole (4.1% versus 4.7%), however, there is concern that this may be an under-estimate. Almost 10% of residents of the Thunder Bay District are Francophone, and they may experience language barriers when accessing health services since the Northwest has limited numbers of French-speaking health professionals.

In March, 2008 the NW LHIN collaborated with the Réseau francophone de Santé du Nord de l'Ontario on a Regional Summit on Health for Francophones in Northwestern Ontario.

On June 3, 2008 the North West LHIN and MOHLTC will co-host a consultation session in Thunder Bay to provide input on the structure, mandate, and membership of the French Language Health Planning Entity (FLHPE).

The North West and North East CCACs are developing of a Directory of Services including a French language component.

2.3.6 Integration of e-Health

The North West and North East LHINs, together with health service providers in the North, have been collaborating to move the health system forward using the knowledge and capacity resulting from the Northern Ontario Information and Communications Technology (ICT) Planning Project.

In recent years, there has been considerable progress made towards the development of an ICT infrastructure in the Northwest, including:

- *Northern Ontario ICT Blueprint, 2005 (Phase 1)* - which focused on hospital, tertiary inpatient mental health hospitals/programs, CHCs (Community Health Centres), CCACs and regional hospital/program ICT needs and strategies;
- *Northern Ontario ICT Blueprint, 2007 (Phase 2)* - was undertaken after the completion of Phase 1 and assessed the current state of health information and communication technology throughout Northern Ontario. The Blueprint planning process involved approximately 400 organizations, 200 community pharmacists, 42 nurse practitioners, 28 Family Health Teams, and 1,100 physicians;
- *Northern Ontario ICT Blueprint, Summer 2007 (Phase 3)* - Phase 3 included all sectors that participated in Phase 1 or Phase 2, and was focused on priority setting, tactical and implementation planning, along with resource requirements and technological solutions;
- Ontario North e-Health Steering Committee which was established to implement the ICT Blueprint and is active in the areas of Picture Archiving and Communication System (PACS), electronic health record (EHR) and back office initiatives; and,
- Innovative e-Health and related models such as the Northwest Health Network's joint ventures in electronic health records and Diagnostic Imaging (DI)/PACS, Ontario Telemedicine Network (OTN), Northern Ontario Hospital Back Office Services project (NOHBOS), and participation in the provincial Electronic Children's Health Network (eCHN).

Northern Ontario ICT Blueprint, 2007 (Phase 3)

The Blueprint Tactical Plan (Phase 3) included all Phase 1 and Phase 2 sectors, and focused on priority setting, tactical and implementation planning, including further detailing for ICT governance and coordination structure to support the priority projects.

Short-, medium- and long-term ICT priorities for Northern Ontario were identified, along with resource requirements and technological solutions. Although the integrated approach between the two Northern Ontario LHINs continued, each LHIN produced a tactical plan that recognized the differences in the e-Health ICT environment of the two LHINs as well as some of the priority change areas that differed between the two LHINs' IHSPs. LHIN-specific plans included the development of LHIN-wide ICT standards, requirements for interoperability and best practices, and system integration approaches.

In 2007, a joint project management office (PMO) was created by the North West and North East LHINs. The role of this PMO is to implement the initiatives identified under the Northern Ontario ICT Blueprint. Additionally, an advisory team was established within the North West LHIN to provide advisory services on e-Health initiatives to the LHIN.

2.3.7 Regional Health Human Resources Plan

Sustaining an adequate supply of qualified health care workers across disciplines is an ongoing challenge throughout the Northwest. Until recently, there was no comprehensive health human resource planning at the national, provincial, or local level. The *Integrated Service Plan for Northwestern Ontario*, Report of Special Advisor, Tom Closson (2005), noted a severe shortage of health human resources (HHR) in the Northwest. The *Northwestern Ontario Health Human Resources Study* completed by the Northwestern Ontario District Health Council (2002) also identified this issue. HealthForceOntario (HFO) is currently undertaking a provincial strategy of unprecedented magnitude. An early win resulting from this provincial strategy is the creation of the Physician Assistant position. These clinicians assist their supervising physicians to deliver services within the patient care team, thereby reducing the demand for physicians.

The North West LHIN Emergency Department (ED) Lead is working with HealthForceOntario to address physician coverage in emergency departments in the Northwest. The North West LHIN ED Lead and Thunder Bay physicians are participating in a Regional Group Locum Program to assist urgent shifts in Dryden, Kenora and Fort Frances. This initiative also includes involvement with HealthForceOntario's Locum Credentialing Application Program to ensure privileges to cover shifts in the participating hospitals and allow for more efficient and timely shift coverage.

Providing opportunities for students to live, study, and practice in the Northwest supports the establishment and maintenance of a strong health care workforce. The new Northern Ontario School of Medicine (NOSM), a joint initiative between Laurentian University and Lakehead University, is expected to provide such an opportunity and thus contribute to improving the supply of physicians in Northern Ontario.

The North West LHIN is engaged with health service providers in exploring innovative ways of sustaining an adequate supply of health professionals in the region. The North West LHIN's Health Human Resources Roundtable and newly formed Health Professionals Advisory Committee (HPAC) will serve as forums for discussion and advancing HHR initiatives in the Northwest. The twelve Family Health Teams (FHTs) in the North West LHIN are embarking on the implementation of innovative interprofessional practice models which will more fully utilize the skills of the health professionals involved. The FHTs are well positioned to enhance access to primary care through improved utilization of existing health human resources. The Sunset Family Health Team (Kenora) is schedule to participate in the first wave of Quality Management Collaboratives.

The North West LHIN supports the placement of a Nurse Practitioner-led clinic in the Northwest, recognizing the number of unattached clients/patients and the valuable role and skills Nurse Practitioners bring to an interprofessional team, increasing access to family health care.

The potential for interdisciplinary learning is expanding in the North West LHIN as the number of health professional programs increases. The North West LHIN is working collaboratively with academic health sciences programs to facilitate this team approach to learning and practice and continues to host information sessions where experts have provided information about successful experiences in inter-professional care and education and resulting improved access to care.

3.0 Detailed Plans to Implement IHSP Priorities

Note: Many of the objectives for each of the priorities for change extracted from the North West LHIN's *Integrated Health Services Plan* and presented in this Annual Service Plan are long-term and will require more than three years to achieve. The specific strategies identified in this plan are intended to advance the objectives over the coming three years. It is acknowledged that achievement of the desired future states presented for each of the strategic priorities will take place over the longer term.

3.1 Access to Care

3.1.1 Access to Primary Health Care

Desired Future State:

Interdisciplinary teams with members working to their full scope of practice will increase access to family health care. Clients will receive care from the right health practitioner in the right place at the right time.

This team approach will improve the management of chronic disease and increase the time available for prevention and self-management activities, thereby reducing the episodes of acute exacerbation and reliance on Emergency Departments for care. Where appropriate, community based peer groups will support self-management and reduce reliance on the formal health care system.

The use of an integrated electronic health record (EHR) will create efficiencies through improved communication and better coordination of services. Better management of chronic diseases through the use of information technology will result in decreased demand for the acute care system and primary care providers.

Health professional education programs at the Northern Ontario School of Medicine, Lakehead University and Confederation College specializing in northern/rural/remote practice will continue to be effective in recruiting clinicians to practice settings in Northwestern Ontario. Opportunities for teaching, research and professional development through the existence of these programs will help to retain clinicians.

The use of telemedicine will be expanded. This expansion will further increase access to primary care in remote areas and will provide decision support for generalist practitioners in small communities by connecting them with specialists in larger centres, thereby reducing professional isolation and increasing retention.

The objectives specifically related to improving access to primary care in the IHSP are:

1. Increase the percentage of the population with regular access to a primary health care provider or team of primary health care providers;
2. Better integrate hospitals in smaller communities into the delivery of primary health care;
3. Reduce the reliance on urban EDs for primary health care; and
4. Promote more coordinated care in community-based and non-emergency settings.

Current State:

The need for improved access to primary care services was identified as an important concern in virtually all community engagement sessions; physician shortages were of particular concern.

Though communities in the North West LHIN have experienced challenges in the recruitment and retention of primary health care providers for some time, the growing shortage throughout the province and beyond has exacerbated the challenge. New interdisciplinary practice models such as the Family Health Teams (FHTs) are being developed. Twelve FHTs have been approved for the North West LHIN and are in various stages of development. FHTs utilize the skills of multi-disciplinary teams to provide more accessible family health care. Other innovative approaches to the provision of primary care in the North West LHIN include the Community Health Centres in Thunder Bay (satellite offices in Longlac and Armstrong) and Ignace, the NorWest CHCs' Mobile Unit, and three Aboriginal Health Access Centres in Thunder Bay, Keewatin and Fort Frances. The North West LHIN supports the location of a Nurse Practitioner-led clinic in the Northwest.

The North West LHIN established a Health Human Resources (HHR) Roundtable and Community of Interest that will identify and champion innovations to support improved access to primary care practitioners. Their work is closely aligned with that of HealthForceOntario. Membership includes physicians and other health professionals, administrators, educators and community members. Primary Care is an initial focus of the HHR Roundtable and Community of Interest. The Health Professionals Advisory Committee (HPAC) will also support the link between health professionals and the identification of priorities, new models of care and opportunities to improve access to services (including family health care).

Priority related MLAA Indicators:

Readmission rates for Acute Myocardial Infarction (AMI); Percentage of Alternate Level of Care (ALC) days; Percentage of Emergency Department (ED) Visits that could be managed elsewhere; and Hospitalization rate for Ambulatory Care Sensitive Conditions (ACSC).

Access to Primary Health Care Multi-Year Plan*

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
Identify and champion innovative strategies for health service providers (HSP) to work at their full scope of practice by: ▪ Communicating and championing HealthForceOntario (HFO) initiatives ▪ Enhancing capacity for change through knowledge transfer between health service providers and experts in the area ▪ Convening the HPAC and HHR Roundtable to generate innovative ways of practicing to full scope ▪ Hosting conversations with primary care providers such as physicians and nurse practitioners	▪ HSPs ▪ HFO ▪ HHR Roundtable ▪ Community of Interest ▪ MOHLTC ▪ Health professional programs ▪ HPAC				▪ Enhanced knowledge/understanding of scope of practice potential (e.g. best practices and opportunities) in the NW LHIN will be achieved. ▪ The initial point of contact for primary care may be with a non-physician provider, and will improve access to primary care. ▪ Clients will be seen by the most appropriate provider as they enter the health system and throughout their care, increasing the availability of primary care physicians for cases requiring their scope of practice. ▪ Job satisfaction amongst providers working to their full scope will be increased and retention improved.

*This IHSP priority advances the MOHLTC's priority of Family Health Care for All

Continue to pursue the development and implementation of the e-Health initiative including: ▪ Electronic health record (EHR) ▪ e-Physician ▪ e-Pharmacist ▪ Enhanced telemedicine capacity and opportunities.	▪ Family Health Teams (FHTs) ▪ Advisory Teams ▪ Communities of Interest ▪ HSPs ▪ Ontario Telemedicine Network (OTN)				▪ Improved communication regarding the health status of clients will reduce duplication and improve quality of care. ▪ More effective and efficient use of existing primary care providers will increase access for clients. ▪ Improved chronic disease management will result from implementation of the e-Health initiative.
Champion inter-professional learning and practice.	▪ Academic health sciences partners ▪ FHTs ▪ CHCs ▪ HFO ▪ HSPs ▪ HHR Roundtable ▪ HPAC				▪ HSPs will have increased involvement with innovative HFO programs. ▪ Clinicians will be better prepared to work as practice teams. ▪ A greater number of HSPs will be working in inter-professional teams. ▪ Opportunities for inter-professional education and learning will be increased.

3.1.2 Chronic Disease Prevention and Management (CDPM)

Desired Future State:

A culture of enhanced personal responsibility for health will result in lifestyle modifications leading to lower rates of obesity, smoking and alcohol consumption and an emphasis on increased physical activity. It is anticipated that the prevalence of chronic disease will decrease as a result. This is a long-term strategy to be achieved through the efforts of effective health promotion and illness prevention initiatives. Effective partnerships exist across sectors to improve the health of the community.

The health system will be transformed to better manage chronic diseases when they do occur. The approach will be client centred. Timely access to primary care will ensure that clients interface with the right provider at the right time, in the right place, reducing the acute episodic exacerbations which result in the use of the acute care system for chronic disease management. Primary care will incorporate evidence-based guidelines, producing improved clinical outcomes.

Supportive programs will enable clients to confidently manage their chronic illnesses in the community. Community tertiary prevention programs such as exercise programs for clients with chronic disease and peer support groups will also be in place. Quality of life for individuals 'aging at home' with chronic disease will be improved through improved access to supportive care. Regular visits with primary care providers in times of "wellness" will also support healthy living in the community.

Advances in e-Health will lead to better sharing of client information, efficiencies and health outcomes. Client records will be easily accessible across the health continuum, leading to reduced duplication, improved communication and follow up, and enhanced implementation of evidence based guidelines.

The objectives specific to CDPM outlined in the IHSP include:

1. Reduce the episodes of acute care related to chronic diseases;
2. Improve access to treatment and disease management services for people with chronic diseases; and
3. Reduce the incidence and prevalence of chronic diseases in Northwestern Ontario.

Current State:

The health status of residents in the North West LHIN falls below that of residents in other parts of the province on a number of measures. Currently, the expected lifespan for both men and women in the Northwest is the lowest in the province. Rates of obesity, smoking and alcohol consumption are higher than in other areas of the province. Northwestern Ontario residents experience diabetes, arthritis/rheumatism, hypertension, asthma and heart disease at reported rates that exceed provincial averages. Of particular concern is the prevalence of diabetes in the Aboriginal population. Primary prevention programs are an essential component of attaining the desired future state.

In order to transform the health system in accordance with the CDPM framework, a readiness for change must exist. Capacity for change has been enhanced in the North West LHIN through the hosting of several knowledge transfer sessions with experts in the field of primary care reform and effective chronic disease prevention and management.

Access to primary care is a challenge in the North West LHIN. Insufficient access results in wait times, during which a chronic condition may become acute, increasing the number of clients accessing primary care services through the emergency department (ED) and/or increasing the number of admissions to acute care. It is difficult for optimal chronic disease management to occur in the context of chronic primary care shortages.

It is anticipated that the expansion of practice teams will improve access to primary care for residents of the North West LHIN. Practice settings such as Family Health Teams (FHT), Community Health Centres (CHC), and Nurse Practitioner-led clinics are examples of models that may better support optimal chronic disease management. With a specific mandate to prevent and manage chronic disease, it is expected that FHTs will improve outcomes and foster innovation in the Northwest. At this time, the FHTs are in the early (and varying) stages of development.

Capacity for self-management is developing in the North West LHIN. To date, 28 health service providers have completed the Master level training through Stanford University – a learning opportunity facilitated through the LHIN. Additional self-management training has also been provided throughout the region.

There is a need to advance e-Health in order to enable the practice of evidence-based chronic disease prevention and management. Currently, many physicians outside of the FHTs and CHCs continue to use paper records. As increasing numbers of health service providers invest in information technology (IT), it is apparent that there is a need to ensure compatibility.

The North West LHIN CDPM Advisory Team is established. Detailed action planning to advance a strategy is underway.

Priority related MLAA Indicators:

The LHIN and the CDPM Advisory Team will develop specific indicators building on the CDPM provincial framework and environmental scan such as: Readmission rates for AMI; Rate of ED Visits that could be managed elsewhere; and Hospitalization Rate for ACSC.

Chronic Disease Prevention and Management Multi-Year Plan

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
Continue to pursue the development and implementation of the e-Health initiative including: ▪ Electronic health record (EHR) ▪ Client and provider portals ▪ Provider decision support ▪ e-Physician ▪ e-Pharmacist ▪ Enhanced telemedicine capacity and opportunities. A Chronic Disease Information Management System will be put in place to provide primary care practitioners with decision support.	▪ Health Service Providers (HSPs) ▪ MOHLTC ▪ Vendors ▪ North East LHIN				▪ Improved sharing of information amongst providers will reduce duplication, increase efficiencies and improve quality of care. ▪ With the capacity to roster clients, primary care practitioners will be guided through assessments related to specific chronic diseases in keeping with best practices, thereby preventing or postponing complications and acute exacerbations. ▪ There is potential to improve the quality of life for clients through better disease management and to reduce the number of acute admissions for chronic illnesses.

					▪ Data collection will also be facilitated through the creation of client rosters.
Build capacity for authentic change through knowledge transfer.	▪ HSPs ▪ Other LHINs ▪ Recognized experts in the field of CDPM				▪ Providers and consumers in the North West LHIN will better understand the system transformation required to facilitate adoption of the CDPM framework of the MOHLTC and the enormous benefits to clients and the health system in moving forward with this transformation. ▪ A state of “readiness for change” will be achieved.
Improve self-management by: ▪ Improving education and support for clients throughout the continuum of care ▪ Developing of telehomecare or other community supports ▪ Expanding of community exercise programs for clients ▪ Stanford self-management groups hosted in communities throughout the region ▪ Facilitating meetings to share successes and address challenges amongst Master Trainers	▪ Other LHINs ▪ HSPs ▪ Clients ▪ CDPM Master Trainers				▪ Clients will have increased confidence and success in self-management of their illnesses. ▪ The number of acute episodes of chronic illness will be reduced. ▪ Access to quality self-management programs will be greatly enhanced throughout the region.

3.1.3 Priority: Access to Specialty Care

Desired Future State:

Access to specialty services will be enhanced for clients throughout the region, by minimizing travel for specialists and clients through the expanded use of telemedicine and the implementation of the provincial e-Health initiative and the ICT Blueprint.

A greater number of specialists will be using telemedicine and connectivity of specialists across the broader health system will be enhanced through the use of e-Referrals, Electronic Health Record (EHR), etc.

Access to specialty services will also be enhanced by increasing the capacity of specialists through educational opportunities and the use of specialty trained health professionals and sub-specialists. In addition, access to specialty care will be enhanced through planned improvements in access to primary care, resulting in reductions in the use of specialists for routine procedures.

It is anticipated that recently announced transportation programs, through the Aging at Home Strategy, will contribute to improved access to specialty services by allowing seniors to utilize vans for necessary medical transportation.

The specific objectives outlined in the North West LHIN IHSP are:

1. Reduce the number of unnecessary referrals to specialist physicians;
2. Reduce the wait time for initial access to a specialist physician; and
3. Reduce geographic barriers to accessing specialist physicians.

Current State:

Specialty services are available through the use of technology at all Northwest hospitals, the North West Community Care Access Centre (CCAC) and remote northern First Nations communities. Linked through the Ontario Telemedicine Network and/or Keewaytinook Okimakanak Telemedicine, consultation, assessment and follow-up visits with specialists occur remotely. Some of the specialty services that are provided to the smaller, rural and remote communities using this technology include: telepsychiatry, teledermatology, teleopthalmology and telecardiology.

In 2007, the North West LHIN created a Wait Time Strategy Advisory Team that provides advice to the LHIN on the implementation of the Wait Time Strategy (WTS). The team's focus is congruent with the provincial WTS. The LHIN continues to monitor wait times in the Northwest on a regular basis and communicate with the Ministry and the regional hospitals participating in the WTS on strategy, challenges and performance. Three WTS Working Groups have been developed to address the following wait time issues:

- Magnetic Resonance Imaging/Computerized Tomography (MRI/CT);
- Cataract surgery; and
- Hip and knee replacement surgery.

It is expected that two other WTS Working Groups will be developed in the near future related to:

- General surgery; and
- Emergency Department wait times.

The communities of Dryden, Fort Frances and Sioux Lookout submitted proposals for CT scanners. Fort Frances and Dryden have received MOHLTC approval under the Healing Arts Radiation Protection Act (HARP). Fort Frances is expected to have their CT operational by June 2008. Dryden is expected to have their CT operational by early summer 2009. Additionally, in 2008/09, significant investments were made in diagnostic imaging in Thunder Bay with additional allocations from the WTS. These investments are targeted towards reducing wait times for diagnostic imaging services within the North West LHIN.

Cataract surgery has been expanded in the Northwest in the following ways in an effort to lower the growing wait times for this service:

- In Thunder Bay, facilities have been expanded to provide additional space to increase surgical volumes;
- In Marathon, a new cataract program was established that included an eye surgeon travelling from Southern Ontario to perform surgery and a colonoscopy service will be established to support colorectal cancer screening; and
- As of April 2008, the 90th percentile wait time for cataract surgery in the NW LHIN has been reduced from a baseline of 413 days to 146 days.

In 2008/09, Thunder Bay Regional Health Sciences Centre and Sioux Lookout Meno-Ya-Win Health Centre participated in the Paediatric Wait Time Strategy, providing dental and otolaryngological surgery.

The North West LHIN has a Regional Joint Program that supports the WTS, with hospitals from across the region developing and sharing clinical pathways, sharing best practices, addressing resource allocation and identifying and addressing requirements. In this program, orthopaedic surgeons from Thunder Bay travel to Dryden, Kenora and Fort Frances to perform knee and hip replacements.

The WTS also focuses on cancer and cardiac surgery. The North West LHIN works closely with the Regional Cancer Centre and monitors the critical indicators. The proportion of in-hospital cancer deaths versus all cancer deaths has improved significantly over the last five years and there is supporting evidence that the North West LHIN is performing well regarding this indicator. Cancer surgery wait times are one of the lowest in the province with 90% of the cases completed in 54 days well below the provincial target of 84 days.

It 2007/08, TBRHSC was approved and began operating a stand-alone angioplasty program. This program aims to reduce the number of residents from the Northwest who must travel to have this procedure performed. No cardiac surgery is available in the Northwest.

In 2008/09, the WTS will be further expanded to cover general surgery, ophthalmology, and all orthopaedic surgery. The North West LHIN will monitor the hospitals' performance in relation to established performance targets and work with the hospitals to improve access to these procedures where issues are noted.

In 2006, in alignment with the Ontario Critical Care Strategy, a Critical Care LHIN Lead was appointed for the Northwest to look at challenges associated with access, quality and system integration for critical care, including surge capacity and patient transfers. The LHIN meets with the Critical Care LHIN Lead on a regular basis to communicate information and updates on the strategy.

There are several mobile health services in the Northwest that provide diagnostic and therapeutic services to residents across all or parts of the region, including:

- Eye Screening Van;
- Breast Screening Coach; and
- In June 2007, the NorWest Community Health Centres implemented a mobile unit that travels to under serviced communities within the District of Thunder Bay. A Nurse Practitioner travels on the mobile unit to provide urgent care clinics in selected communities.

Priority related MLAA Indicators:

90th Percentile Wait Times for Cancer Surgery; 90th Percentile Wait Times for Cataract Surgery; 90th Percentile Wait Times for Hip and Knee Replacement; 90th Percentile Wait Times for Diagnostic Imaging; Readmission rates for AMI; and Rate of ED Visits that could be managed elsewhere.

Access to Specialty Care Multi-Year Plan

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
Continue to pursue the development and implementation of the e-Health initiative as this has a significant positive effect on access to specialty services. This should include: ▪ e-Referral; ▪ electronic health record (EHR); ▪ e-Physician; ▪ e-Pharmacist; and ▪ Telemedicine capacity and opportunities.	▪ Advisory Teams ▪ Other LHINs ▪ HSPs ▪ System Integration Committee ▪ Workgroups				▪ All access points in the health system will be linked electronically to provide safe, secure access and transmission of client information. ▪ Access to specialists will be improved and wait times reduced to access a specialist.
Ensure wait time targets are achieved for: ▪ Hip and knee replacement; ▪ Cataract surgery;	▪ Advisory Teams ▪ System Integration Committee ▪ HSPs				▪ Wait time targets negotiated between the MOHLTC and the LHIN for the Ministry-LHIN Accountability Agreement will be achieved.

▪ Cancer surgery; ▪ MRI and CT; and ▪ Cardiac surgery.	▪ CCAC ▪ Hospitals ▪ MOHLTC ▪ WTS				
Develop and maximize the use of innovative models and best practice for specialty care service delivery including: ▪ Education and training to ensure appropriate referrals are made for specialty services. This could include standardized assessments, checklists for symptoms and diagnosis; ▪ Use of sub-specialists; ▪ Use of nurse trained anesthetists; ▪ Education and training on the use of telemedicine and e-Health initiatives; ▪ Expansion of OTN to other specialty care services; ▪ Visiting specialists program; ▪ Implementation of regional queuing tools; and ▪ Triage and screening tools for wait lists, etc.	▪ Ontario Medical Association ▪ Ontario Hospital Association ▪ Advisory Teams ▪ System Integration Committee ▪ Physicians/Specialists ▪ Hospitals ▪ Family Health Teams (FHTs) ▪ Other LHINs ▪ MOHLTC ▪ OTN				▪ Improved understanding of appropriate referral patterns, with new models established to reduce the number of unnecessary referrals to specialist physicians and reduced wait times to access a specialist. ▪ More effective and efficient use of the existing specialists with evidence that wait times to access a specialist are reduced.

3.1.4 Priority: Access to Mental Health Services and Addiction Services

Desired Future State:

Through communication and collaborative planning, there will be improved service coordination and access to mental health and addiction services across the Northwest. An increased range and access to specialty care will result. Additionally, there will be shared learning and implementation of best practices. Coordination and communication between mental health and addiction services and with other health sectors will support access and care across the continuum.

The specific objectives outlined in the North West LHIN's IHSP are:

1. Reduce the barriers to accessing existing mental health and addiction services;
2. Expand the capacity to provide mental health services and addiction services; and
3. Improve the effectiveness of mental health services in treating and managing mental health disorders.

Current State:

The delivery of mental health and addiction services is fragmented in the North West LHIN. There are many small and diverse service organizations. A significant number of challenges with access to mental health and addictions services and coordination of these services are experienced in communities across the Northwest.

While the Northwest contains only 2% of the population of Ontario, area residents comprise 10% of the total Ontario substance abuse and problem gambling clients.

Many individuals with a medical condition have concurrent mental illness and/or serious substance abuse issues. Limited availability of mental health and addiction specialists and vast geography creates barriers to accessing specialized mental health and addiction services in Northwestern Ontario.

There is limited access to psycho-geriatric services, including limited 24-hour care.

Deaths due to suicide are a major social and health care issue, with rates of suicide more than double the provincial average. Crisis care mental health services are available in Kenora and Thunder Bay, with all other communities relying on telephone access to these services. Long wait times create barriers to accessing these services in a timely manner. There are access issues for those requiring transitional or supportive housing and walk-in mental health and addictions services. There is a shortage of programs for those requiring more than 60 days of treatment and there are limited stabilization units/safe beds for mental health crisis.

In 2006, an operational review of Acute Mental Health Services at Thunder Bay Regional Health Sciences Centre (TBRHSC) emphasized the importance of coordination of Schedule 1 services (i.e. TBRHSC and Lake of the Woods District Hospital) with those providing longer-term mental health services.

The Kenora/Rainy River Mental Health and Addictions Network and the Thunder Bay District Mental Health and Addictions Network have formal linkages through joint memberships in order to promote region-wide integrated planning. Representatives of these networks sit on the Northwestern Ontario Mental Health and Addictions Services Network (NWOMHASN). All mental health and addictions agencies are working with Dr. Kenneth Minkoff and Dr. Christie Cline who are conducting an assessment of potential system integration. NWOMHASN will look at the results of these assessments and determine opportunities for integration. A plan is expected by June 2008.

Priority related MLAA Indicators:

Hospitalization rate for Ambulatory Care-Sensitive Conditions (ACSC) and Rate of ED Visits that could be managed elsewhere.

Access to Mental Health Services and Addiction Services Multi-Year Plan

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
Explore opportunities for realignment of mental health and addictions services to better meet client needs in the North West LHIN. Review system integration opportunities identified by Minkoff and Cline assessment and other relevant resources.	▪ Mental Health and Addictions Services Advisory Team ▪ System Integration Committee ▪ Community of Interest ▪ Northwestern Ontario Mental Health and Addictions Services Network ▪ MOHLTC ▪ Health Service Providers (HSPs)				▪ Gaps and duplication in mental health services will be identified. ▪ Opportunities for realignment will be identified. ▪ Program realignment to better meet client needs will be initiated. ▪ Access to mental health and addiction services will be improved.
Indicators will be developed and meaningful data collected to inform ongoing planning for mental health and addiction services by: ▪ Building on work of MOHLTC in data collection (e.g. MDS, MIS); and ▪ Working with local providers and MOHLTC to identify meaningful indicators.	▪ HSIP ▪ MOHLTC ▪ HSPs				▪ Realignment of services will be evidence-based. ▪ Service Accountability Agreements will have informed integration plans.

Facilitate the closure of St. Joseph's Care Group's Lakehead Psychiatric Hospital (LPH) site and realignment of services in the community.	▪ HSPs ▪ St. Joseph's Care Group ▪ MOHLTC ▪ Advisory Team ▪ Community of Interest				▪ Appropriate community mental health services will be in place enabling the closure of St. Joseph's Care Group's Lakehead Psychiatric Hospital.

3.2 Availability of Seniors' Services

Desired Future State:

Working with providers, communities, seniors and their caregivers there will be an integrated system of community based services that enable seniors to live safely at home with independence and dignity. This will include a full spectrum of services available to people across the continuum of care to improve the care for seniors, support quality of life and aging at home in the most appropriate place.

The specific objectives outlined in the North West LHIN's IHSP to improve Seniors' Services are:

1. Reduce the number of people requiring residential long-term care;
2. Reduce the length of time people wait in acute care hospitals for access to long-term care; and
3. Reduce the length of time people wait in the community for access to long-term care.

The North West LHIN's Aging at Home Service Plan will align with the provincial Aging at Home Strategy with a focus on the following priorities:

- Reducing length of hospital stay for seniors;
- Decreasing unnecessary admissions to long-term care homes and hospitals;
- Promoting the health and safety needs of seniors;
- Providing community supports that maintain the independence of seniors through partnerships and collaborative care initiatives; and
- Focusing on innovation, economic development and non-traditional partnerships for service delivery.

Current State:

The Northwest has a slightly higher proportion of people 65 years or older compared to the province. The lack of new immigrants, slow population growth and continued youth out-migration contribute to the older age of Northwestern Ontario's population. At the same time, the population under 65 is beginning to decline; there is concern that care typically provided by caregivers will no longer be sustainable as the population ages. Furthermore, the youth out-migration represents a loss of potential formal care providers. Securing skilled caregivers is increasingly an issue for many communities and seniors in the Northwest.

Access to services is an ongoing challenge in the North West LHIN. Many seniors outside of Thunder Bay must travel great distances to access specialty services. As road conditions are less than optimal for several months of the year and the drive to services is often long and isolated, many seniors choose not to travel.

Services for seniors across the continuum of care are not consistently available throughout the North West LHIN. Cultural and linguistic requirements may also present a barrier for seniors accessing services. As well, there is an identified and documented shortage of home support services and supportive housing for seniors across the Northwest.

The use of technology has helped to improve access to services. A number of specialists use the Ontario Telemedicine Network (OTN) to conduct appointments with their patients, including the one geriatrician who serves the Northwest. Telemedicine not only increases access, but also reduces the need for seniors to travel long distances to access services.

The development of the Centre of Excellence for Integrated Seniors' Services (CEISS) is underway, targeted for completion in 2011. This will include 336 long-term care beds of which 64 beds will be regional, specialized behavioural beds; 132 new supportive housing units; enhanced community support services for 120 new clients; and increased CCAC services for 30 additional clients. The CEISS project improves access to appropriate care and promotes independence by offering an enhanced package of services across the care continuum.

The North West LHIN has issued a Call for Proposals for "Innovative Alternatives that Promote Aging at Home". Proposals must support the priorities as outlined in the North West LHIN's Aging at Home Service Plan.

Priority related MLAA Indicators:

Rate of ED Visits that could be managed elsewhere; Median Wait Time to LTC Home Placement; Percentage of ALC Days.

Availability of Seniors' Services: Multi-Year Plan

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
A Centre of Excellence for Integrated Seniors' Services (CEISS) will be developed in the City of Thunder Bay. The project will include: ▪ Increased community support services (2008-2011); ▪ Increased Community Care Access Centre services (2008-2011) ▪ Supportive housing (enhancements to existing stock and additional units) (2008-2011); ▪ Long-term care home beds (2011); and ▪ Specialty services for dementia clients with responsive behaviours (2011).	▪ MOHLTC ▪ District Social Services Administration Board (DSSAB) ▪ Ministry of Municipal Affairs and Housing ▪ St. Joseph's Care Group (SJCG) ▪ MOHLTC ▪ City of Thunder Bay ▪ CCAC ▪ Community Support Services and Supportive Housing sectors				▪ Increased number of seniors will be able to access services. ▪ Coordinated care along the continuum of services will be enhanced. ▪ Increased supportive housing available for seniors. ▪ Regional resource in place to support clients with dementia and other clients with responsive behaviours. ▪ Staff in long-term care homes will have enhanced opportunities to provide evidence-based care. ▪ Capacity in gerontology practice will be increased through the creation of enhanced learning and research opportunities.
Improve services available to seniors by: ▪ Explore opportunities to realign senior services to better meet their changing needs and preferences. ▪ Engage in research initiatives to	▪ HSPs ▪ Academic health sciences partners ▪ Seniors' Services Advisory Team ▪ Community of Interest				▪ Access to residential long-term care will be improved. ▪ More seniors will be supported to age at home. ▪ Opportunities for program/service realignment will be identified.

better address services for seniors and their caregivers. ▪ Leverage options from the Balance of Care study.	▪ Health System Intelligence Project (HSIP) ▪ Other LHINs				▪ Improved understanding of best practices and models of care for seniors and their caregivers. ▪ Capacity for alternative settings of care delivery will be enhanced.
Work with health service providers to reduce the length of hospital stay for seniors and decrease their unnecessary admissions to hospital and long-term care. ▪ Realign services to support seniors in their homes. ▪ Focus on innovative care approaches and best practices ▪ Develop strategies to address ALC pressures.	▪ MOHLTC ▪ Health Service Providers ▪ Seniors' Services Advisory Team ▪ Other LHINs				▪ Enhances services along the continuum of care exists. ▪ Seniors length of stay in hospital is reduced. ▪ Access to community support services is enhanced. ▪ Unnecessary admissions to hospital and long-term care will be decreased. ▪ ALC pressures are reduced. ▪ Innovative approaches/strategies and models of care exist across the North West LHIN.
Build increased capacity to support aging at home for seniors, their families and caregivers. ▪ Focus on services that maintain/enhance health and safety for seniors. ▪ Increase partnerships and collaborative initiatives for integrated and coordinated care	▪ MOHLTC ▪ Health Service Providers ▪ Seniors' Services Advisory Team ▪ Seniors' Organizations ▪ Municipalities ▪ Academic Institutions				▪ Improved safety programs/services exist e.g. falls prevention. ▪ Innovative approaches/strategies for integrated services exist in the Northwest. ▪ Increased number of partnerships and linkages with non-traditional providers are in place.

for seniors in the community. ▪ Develop linkages/partnerships with non-traditional providers. ▪ Encourage economic development initiatives that support services for seniors. ▪ Pursue e-Health initiatives that assist seniors in maintaining independence i.e. telehomecare.	▪ Other LHINs				▪ Supports exist for seniors and caregivers. ▪ Seniors have increased access to services through telemedicine. ▪ Seniors length of stay in acute care is reduced.

3.3 Integration of Services Along the Continuum of Care

Desired Future State:

A culture of improved communication, linkages, partnerships and coordination of health care services will exist in Northwestern Ontario. Residents will find that there is 'no wrong door' to access health care services in the Northwest. Clients will experience a seamless system of care, with an ability to move between and among services/sectors of care. Client centered care will improve the quality of care and integration of care across the continuum. Emergency department pressures will be reduced and patients will be connected to alternatives for non-emergency health care services.

Strong linkages will exist across government, ministries, business and other sectors.

The specific objectives outlined in the North West LHIN's IHSP are:

- Improve the timeliness of care;
- Improve the effectiveness of care;
- Improve the efficiency of care;
- Innovative community-based approaches to care will exist; and
- Access to more alternatives for non-emergency health care services will exist.

Current State:

The North West LHIN, through ongoing community engagement and communications, will continue to support a culture of working together to build a strong integrated health care system in the Northwest.

The North West LHIN will support the planning and implementation of strategies to improve the integration of services and service provision along the continuum of care. Initiatives aimed at increasing access to community health services will continue to be implemented for patients needing long-term or community based care through the Centre of Excellence for Integrated Seniors' Services (announced August 31, 2007).

These investments started in 2007/08 with enhancements in funding for 30 high-intensity CCAC clients that require care in the community, in order to address ALC and/or ED pressures. Planning is currently underway to determine how the CEISS investments will be phased in over the next three years.

Investments in TBRHSC were also made in 2007/08 to help improve access to emergency care by developing innovative and sustainable processes to meet individual needs in settings other than the emergency room. This includes the establishment of a Geriatric Emergency Management program, a regional network of providers and two pilot patient navigators for the ED. Over the upcoming year, these initiatives will be evaluated to measure the impact on utilization patterns, patient satisfaction, quality of care and emergency overcrowding. The "Flo" Collaborative, which is a partnership between TBRHSC, St. Joseph's Care Group, the North West CCAC and the North West LHIN was also implemented with one-time funding provided over 2007/08 and 2008/09. The goal of this initiative is to address the flow of patients through the system while expediting discharge to the appropriate setting in a timely manner.

The North West LHIN Emergency Department (ED) Lead is working with HealthForceOntario to address physician coverage in emergency departments in the Northwest. The North West LHIN ED Lead and Thunder Bay physicians are participating in a Regional Group Locum Program to assist urgent shifts in Dryden, Kenora and Fort Frances. This initiative also includes involvement with HealthForceOntario's Locum Credentialing Application Program to ensure privileges to cover shifts in the participating hospitals and allow for more efficient and timely shift coverage.

The North West LHIN is in the process of piloting a priority-setting framework, with the assistance of experts, to assist with resource allocation decisions. The North West LHIN is one of three LHINs that are participating in the pilot. The framework is designed to assist with aligning resources strategically with system goals and community needs while constructively engaging stakeholders in these processes. In 2008/09, the North West LHIN is piloting the framework using the Urgent Priorities Funding for initiatives that address ALC and/or ED pressures. Funding will be provided on a one-time basis, potentially spanning more than one fiscal year, for those initiatives that leverage existing resources in a way that promotes integration, enhanced services and system sustainability. Proposals will be evaluated using the North West LHIN's decision criteria, which have been reviewed with stakeholders and incorporate their feedback. The results of the pilot will be reviewed collectively by all LHINs, with opportunities for improvement and broader scale implementation being developed. A Balanced Scorecard for the North West LHIN is also being developed; the internal organizational section being completed by LHIN staff and experts, the larger system Scorecard to be developed with our health partners across the region.

A Balanced Scorecard for the North West LHIN is also being developed; the internal organizational section being completed by LHIN staff and experts, the larger system Scorecard to be developed with our health partners across the region.

There are several other initiatives underway that support improved linkages, partnerships, coordination and integration of services in the Northwest. Examples include: the collaborative efforts of mental health and addictions in working together to develop a plan for integration of

services for concurrent disorders; several partners working to establish a Centre of Excellence for Integrated Seniors' Services; the establishment of a Total Joint Centre linking the regional hospitals with the tertiary centre; a Regional Diagnostic Services group; a collaborative smoking cessation program between the health units, Dilico Anishinabek Family Health Team and LHIN; and the signing of a collaboration agreement with the North West LHIN and the Northern Ontario School of Medicine.

Priority related MLAA Indicators:

Readmission rates for AMI; Percentage of ALC days; Rates of ED Visits that could be managed elsewhere, Hospitalization Rates for ACSC; and Median Wait Time to LTC Home Placement.

Integration of Services along the Continuum of Care Multi-Year Plan

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
Continue to pursue the development and implementation of the e-Health initiative as this has a significant positive effect on continuity of services. This should include: ▪ e-Referral ▪ EHR ▪ e-Physician ▪ e-Pharmacist ▪ Enhanced telemedicine capacity and opportunities ▪ Directory of services.	▪ Health Service Providers (HSPs) ▪ MOHLTC ▪ Advisory Teams ▪ Communities of Interest ▪ System Integration Committee				▪ The implementation of e-Health initiatives will result in improved communication amongst providers and more seamless and timely care for clients. ▪ The ability to roster clients according to health issues will result in the implementation of care pathways that are based on best practices.

Facilitate ease of navigation of the system for clients by investigating and implementing best practices related to integration such as: ▪ Aging at Home Strategy; ▪ Centre of Excellence for Integrated Seniors' Services (CEISS); and ▪ Regional behavioural resource under the CEISS. Develop and support North West LHIN Advisory Teams, Communities of Interest, System Integration Committee and Working Groups to identify and support system integration in the Northwest by: ▪ Reviewing and facilitating innovative approaches to integration of care; ▪ Championing and celebrating local innovations; ▪ Increasing opportunities to build capacity and support knowledge transfer about best practices; and ▪ Promoting better integration of services.	▪ Health System Intelligence Project (HSIP) ▪ HSPs ▪ System Integration Committee ▪ Advisory Teams ▪ Communities of Interest ▪ HSPs ▪ Public			▪ The capacity for system navigation will be improved. ▪ Patient safety and quality of care will improve. ▪ Transitions along the continuum of care will be more seamless and transparent. ▪ The collaborative teams organized by the LHIN will advance system integration.

Implement strategies that support the provincial priority of improving ED access by: ▪ Monitoring indicators related to the implementation of the Geriatric Emergency Management Program; ▪ Monitoring progress of the anticipated outcomes of the ED Patient Navigator Strategy; ▪ Funding initiatives that promote community based and non-emergency alternative settings for care; ▪ Enhancing better coordinated and integrated home care and community support services for seniors; ▪ Promoting better management of chronic diseases such as diabetes within the community setting; ▪ Improving community-based mental health and addiction treatment; and ▪ Ensuring adequate human resources are available to support ED care.	▪ HSPs ▪ ALC Regional Steering Committee ▪ System Integration Committee ▪ Advisory Teams				▪ Geriatric assessment tools will be used in the ED to stratify and expedite access to services that will better address seniors' care needs. ▪ Expedited access to primary care services. ▪ Non-emergency health care services will be established and linked to family health teams. ▪ Focused and targeted community initiatives for chronic diseases will be implemented to support a reduction in ED wait times. ▪ The percentage of ALC patients within the acute care setting will decrease. ▪ Regional ED locum pool will be in place, ensuring adequate coverage. ▪ The ED network will link regional sites and services virtually to ensure adequate human resources are in place to address ED care.

3.4 Engagement with Aboriginal People

Desired Future State:

The North West LHIN has the highest percentage of Aboriginal people in the province (13.9%); this is substantially higher than the provincial average of 1.7%. The North West LHIN will work with our Aboriginal communities and the federal and provincial governments to address issues of access to health care services to:

- Increase and improve local delivery of health services; and
- Improve the cultural sensitivity of services provided in district and regional centres.

Current State:

Data specifically (and separately) describing health service utilization and health care outcomes for the Aboriginal residents of the North West LHIN are not available. Canadian studies have consistently shown that Aboriginal populations have reduced life expectancy and poor health status compared to the general Canadian population.

In nearly all community engagement sessions, the need for improvement in the health status and access to services for Aboriginal people was identified. In 2007, the North West LHIN continued its commitment of exploring opportunities for community engagement with Aboriginal people by meeting with Aboriginal leaders, First Nation Chiefs and Council members, health service providers and tribal councils. Aboriginal leaders stressed the importance of finding Aboriginal solutions to Aboriginal health concerns.

Aboriginal LHIN Board members conducted a cross-cultural education presentation to LHIN Board and staff to better understand the diverse and dynamic Aboriginal culture and history.

The ability for the North West LHIN to build relationships will take time and requires mutual effort and goodwill. It will also require workable channels of communication from Aboriginal leaders and all levels of government.

Priority related MLAA Indicators:

No specific MLAA indicators apply.

Engagement with Aboriginal People Multi-Year Plan

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
Develop a comprehensive Aboriginal community engagement plan to support a collaborative relationship with Aboriginal people. Hire dedicated staff at North West LHIN to focus on Aboriginal community engagement and planning.	▪ Aboriginal communities ▪ Aboriginal leaders and organizations ▪ Tribal Health Authorities ▪ Provincial Territorial Organizations ▪ MOHLTC – Aboriginal Health Unit ▪ Health Canada ▪ Health Service Providers (HSPs) ▪ Northern Ontario School of Medicine (NOSM) ▪ Local Aboriginal Health Planning Entity				▪ The community engagement plan will enable Aboriginal communities to have greater input in health planning that directly affect their communities. ▪ Community engagement will enable multiple forums for developing relationships. ▪ The volume of Aboriginal-specific community engagement activities will increase. ▪ Aboriginal people will be engaged using methods and ideas suggested by their own people and providers. ▪ Relationships will be fostered and strengthened for ongoing communication and collaboration.

Continue to explore opportunities to coordinate services for Aboriginal people in the North West LHIN.	▪ Aboriginal Communities & HSPs ▪ First Nations and Inuit Health Branch (FNIHB) ▪ MOHLTC – Aboriginal Health Unit ▪ Health Canada – Home & Community Care Branch ▪ Indian and Northern Affairs Canada ▪ Local Aboriginal Health Planning Entity (when developed)				▪ Access to and coordination of services for Aboriginal people will be improved. ▪ Improved sharing of information among providers will support service coordination.

Increase access to telemedicine to improve service delivery in communities.	▪ Ontario Telemedicine Network (OTN) ▪ Keewaytinook Okimakanak Telemedicine ▪ MOHTLC ▪ HSPs ▪ Smart Systems for Health Agency (SSHA) ▪ Other Ministries ▪ Health Canada ▪ Indian and Northern Affairs Canada				▪ Access and coordination of services across the continuum of care will be enhanced. ▪ Rural and remote areas' access to specialty services and continuity of care for clients will increase. ▪ Educational opportunities for providers will increase.
Work with the Local Aboriginal Health Planning Entity (LAHPE) once established, Aboriginal leaders and key stakeholders to obtain information on health and service delivery needs specific to the Aboriginal communities.	▪ Aboriginal communities, leaders, organizations ▪ HSPs ▪ MOHLTC ▪ Local Aboriginal Health Planning Entity ▪ HSIP				▪ The LAHPE will assist the LHIN to engage communities and provide information relative to Aboriginal health issues. ▪ Key health needs and priorities will be identified by working with the MOHLTC, partners and service providers.

3.5 Ensuring French Language Services (FLS)

Desired Future State:
Improved access to French language health services (FLHS) for Francophone residents of the North West LHIN.

Current State:

There are 9,000 Francophones (2006) across Northwestern Ontario, which represents about 4% of the total population of the LHIN. Francophone populations are mainly found in three planning areas (Nipigon, Red Rock, Greenstone; North Shore; Thunder Bay) with scattered pockets in the remaining four planning areas. LHIN staff have met with the Northern French Language Health Services Team (FLHS Team) regarding the latter's work on mapping of the Francophone population compared to total population, distribution of health service providers and the availability of French language services. The FLHS Team also discussed their work with the MOHLTC on the development of a FLHS Decision Support System.

As part of the Hospital Annual Planning Submission (HAPS) process, hospitals that are designated under the *French Language Services Act* or identified to provide services in French are required to complete the integrated French Language Services Report which will serve to inform the process of measuring the relative availability of French language health services.

The North West LHIN conducted focus group sessions on French Language Health Services as part of the development of the *Integrated Health Services Plan*. The focus group will be re-convened on a regular basis to advise the LHIN on how best to address the health care needs of Francophone residents. In March, 2008 the NW LHIN collaborated with the Réseau francophone de Santé du Nord de l'Ontario on a Regional Summit on Health for Francophones in Northwestern Ontario.

On June 3, 2008 the North West LHIN and MOHLTC will co-host a consultation session in Thunder Bay to provide input on the structure, mandate, and membership of the French Language Health Planning Entity (FLHPE).

The North West and North East CCACs are developing of a Directory of Services including a French language component.

Priority related MLAA Indicators:

No specific MLAA indicators apply, however the FLHS is currently working on development of a Decision Support System and FLS Equity Indicator.

French Language Services Multi-Year Plan

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
Work with MOHLTC to further Ministry initiatives relating to French Language Health Services (FLHS).	▪ Health Service Providers (HSPs) ▪ Consumers ▪ MOHLTC ▪ French Language Health Planning Entity ▪ Health System Intelligence Project (HSIP)				Coordination with the MOHLTC will foster congruence of planning activities for French language services with provincial strategies and priorities including MOHLTC's ongoing work on development of a FLHS Decision Support System and Ministry FLS Equity Index.
Work with French Language Health Planning Entity to obtain information on health and service delivery needs specific to the North West LHIN Francophone community and obtain advice on priorities to address those needs.	▪ HSPs ▪ Consumers ▪ MOHLTC ▪ French Language Health Planning Entity ▪ HSIP				The Planning Entity will assist the LHIN to identify and plan for French language health services and engage Francophones in the community; as well as help the LHIN to evaluate, monitor and report on the performance of the health system with respect to French language services.
Work with the French Language Health Planning Entity to host a Francophone Summit to build capacity for change related to chronic disease prevention and management.	▪ French Language Health Planning Entity ▪ HSPs ▪ Consumers				Providers, consumers and experts come together in a capacity building session to enhance awareness of best practices in chronic disease prevention and management with a focus on the Francophone population.

Coordinate a consultation session with the Ministry and the French Language Planning Entity in the North West LHIN to advance planning.	▪ French Language Health Planning Entity ▪ MOHLTC				A consultation session will be held in the North West LHIN to share information and advance system planning between the French Language Health Planning Entity and the MOHLTC.
Work with North West and North East CCACs on roll out of Directory of Services project including French language component.	▪ CCAC ▪ NE LHIN ▪ French Language Health Planning Entity ▪ Funding bodies ▪ 211 Project				The Directory of Services will provide support for consumers and service providers seeking access to the health system by: ▪ Providing referral and consultation services and follow-up information; ▪ Enhancing access to the healthcare system; and ▪ Improving coordination among the sectors and individual providers.

3.6 Integration of e-Health

Desired Future State:

Information and Communication Technology (ICT) supports the processes of quality healthcare provision, access to health information, improvement of consumer outcomes, and the most effective use of available resources across Northern Ontario, through collaboration and sharing information amongst providers and with consumers.

Current State:

In June 2007, a tactical plan (Phase 3) was developed for the implementation of the Northern Ontario e-Health ICT Blueprint. The plan was developed by Northern Ontario health service providers and carried out under the leadership of the two Northern Ontario LHINs.

The Northern Ontario e-Health ICT Blueprints Phases 1 and 2 provided the context and strategies to support health strategies of the Northern Ontario LHINs in innovative yet practical ways to support use of information to improve the health of Northern Ontarians. The purpose of the tactical plan was to develop a single, coordinated work plan for information and communication systems, including current and emerging information and communications technologies within the broad continuum of care in Northern Ontario and within the context of the broader health and e-Health strategies of the Province of Ontario. The process developed consensus on vision, strategies, tactical goals and principles, and activities for information and communication systems in the health care sector over the next four to five years.

Throughout the development of the 3-phased Blueprint, health service providers worked closely with the LHINs, the provincial e-Health Office and other stakeholders to ensure that the Blueprint's priorities were aligned with provincial e-Health plans, Ministry strategic directions and the Northern LHINs Integrated Health Services Plans. The Blueprint project *process* renewed community engagement and partnerships within the health care system. The *implemented* Blueprint will improve the health status of residents by providing equitable access to the care and services they need, regardless of where they live in Northern Ontario or their socio/cultural/economic status, within a framework of health system sustainability.

The Ministry provided the LHIN with $120,000 for the 2008/09 fiscal year. The funding is being used to support the development of the LHIN's e-Health capacity, including the continued alignment of the LHIN with the Phase 3 Blueprint and provincial e-Health Strategy.

An e-Health Advisory Team has been established to provide advice to the North West LHIN on the planning and implementation of clinical and administrative information systems.
Priority related MLAA Indicators: The LHIN, Project Management Office and e-Health Advisory Team will develop specific performance indicators building on the Northern Ontario Blueprint – Phase 3.

ICT Multi-Year Plan

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
Develop a regional ICT infrastructure, support and integration program, including building the foundation for the regional electronic health record (EHR) and developing a technology integration framework, architecture and standards. Establish the EHR within individual organizations.	▪ MOHLTC ▪ NE LHIN ▪ HSPs ▪ ONe-Health				▪ Improved sharing of information amongst providers will reduce duplication and increase efficiencies. ▪ Service provider efficiency will increase and the number of vendors across sectors will be minimized.
Increase Smart Systems for Health Agency (SSHA) Connectivity and ONE Mail between and within organizations	▪ HSPs ▪ Physicians ▪ SSHA				▪ Secure communication of confidential information among service providers will be achieved.

including all physicians (not covered by other provincial e-Health initiatives).	▪ MOHLTC				▪ Electronic information sharing between service providers will expand.
Leverage the provincial Enterprise Master Person Index (EMPI) to provide the means of uniquely identifying clients across the North.	▪ MOHLTC ▪ SSHA ▪ HSPs ▪ NE LHIN				▪ Clients will be uniquely identified.
Increase access to telemedicine to permit service providers to deliver, and clients to receive services and transmit information.	▪ OTN ▪ KO Network ▪ MOHTLC ▪ HSPs ▪ SSHA				▪ The coordination and quality of service delivery across the continuum of care will be enhanced. ▪ Clinical outcomes will be improved. ▪ Rural and remote areas to specialty services for clients will be increased. ▪ Prevention and early diagnosis and treatment of clients will be enhanced. ▪ Educational opportunities for providers will be increased.
Establish a clinical provider portal to provide clinicians with a single point of reference for all patient interactions.	▪ SSHA ▪ HSPs ▪ MOHLTC ▪ NE LHIN				▪ Quality of care through improved access to clinical information will be enhanced. ▪ Electronic information from any service provider will be available.

Develop and implement an e-Referral solution that will provide the means for passing information from a client from one health care provider to another.	▪ Public ▪ HSPs ▪ MOHLTC ▪ NE LHIN				▪ Ability to transfer appropriate information between service providers for an effective referral for services (e.g. discharge profiles, request for services) will exist.
Develop and implement an e-Physician strategy that includes communication portal, office electronic medical record, access to Ontario Telemedicine Network (OTN) and SSHA, etc.	▪ MOHLTC ▪ OntarioMD ▪ Physicians ▪ NE LHIN				▪ Integrated view of patient information will be achieved. ▪ Information from physician office records will be available. ▪ Physician connectivity and those services to which they need to link will increase (e.g. office EMR, Access to OTN and SSHA).
Develop standard administrative systems to support planning, operations and evaluation of health care services.	▪ MOHLTC ▪ HSPs ▪ SSHA ▪ ONe-Health ▪ NE LHIN				▪ Data sharing will be possible, enabling system-wide projects such as system-wide management information reporting.
Implement the Pan Northern Ontario Picture Archiving and Communications System (PACS) Project (PNOPP).	▪ MOHLTC ▪ HSPs ▪ ONe-Health ▪ NE LHIN				▪ Clinician productivity and flexibility on a regional basis including business continuity for film-less sites will improve. ▪ Existing investments (e.g. MRIs, CTs) will be optimized through reducing avoidable retakes.

Expand the Emergency Room Ontario Drug Benefit (OBD) Viewer Access.	▪ MOHLTC ▪ HSPs				▪ Access to drug profiles within OBD will be provided.
Implement the Northern Ontario Directory of Services of health and related service providers as a single source of information regarding health care services within the two LHINs (project managed by the CCACs).	▪ HSPs ▪ NE LHIN ▪ CCACs				▪ Clients will have increased success in seeking referral and consultation services.
Develop a consumer portal as a central point of access to direct local clients to a range of resources regarding the health care services available within the two LHINs.	▪ MOHLTC ▪ HSPs ▪ NE LHIN				▪ Clients will have increased confidence and success in self-management of their illnesses. ▪ Public's access to information and ability to communicate will be increased.
Implementation of the Ontario Laboratory Information System (OLIS) system.	▪ MOHLTC HSPs ▪ NE LHIN ▪ ONe-Health ▪ Physicians				▪ Timely access to laboratory test ordering and results will be achieved.

3.7 Regional Health Human Resources (HHR) Plan

Desired Future State:

Northwestern Ontario will be recognized as a leader in northern/rural/remote health care delivery and generalist practice. Health professionals will work to their full scope of practice, creating efficiencies in the system. Clinicians will have enhanced job satisfaction, positively impacting recruitment and retention.

The LHIN will work with post-secondary institutions and health service providers to enhance access to health professional programs in the North. There will be many opportunities for professional development for practicing clinicians, decreasing professional isolation.

The following objectives identified in the IHSP are mechanisms to facilitate the desired future state.

1. Develop an understanding of current HHR requirements across the North West LHIN and each sub-area; and
2. Initiate activities to develop a model, in alignment with HealthForceOntario (HFO), for the most effective and efficient recruitment, distribution and retention of HHR in the sub-areas of the Northwest.

Current State:

The North West LHIN continues to experience health human resource shortages, particularly in more remote communities. In 2006, the Institute for Clinical Evaluative Sciences (ICES) report *Physician Services in Rural and Northern Ontario* indicated that HHR planning must include retention strategies and systemic solutions (i.e. policy to increase the number of available International Medical Graduates and training specialists to work in rural areas).

In May 2006, HealthForceOntario was announced by the MOHLTC. It is designed to help Ontario identify its health human resource needs, develop new provider roles to meet our changing health needs, work closely with the education system to develop people with the right knowledge, skills and attitudes and to prepare Ontario to compete effectively for health care professionals. With HealthForceOntario's responsibility for retention and recruitment, the North West LHIN continues to align with its activities.

The Northern Ontario School of Medicine (NOSM) is expected to contribute to the physician supply in Northwestern Ontario. In addition to the medical education through NOSM, Lakehead University and Confederation College provide a wide range of health care education programs. It is anticipated that programs which train physicians, nurses and other health care professionals in the North for the North will be effective in enhancing recruitment and retention throughout the region.

In the spring of 2007, the North West LHIN established a Health Human Resources (HHR) Roundtable to identify HHR innovations to support the IHSP and the provincial HHR Strategy. The North West LHIN's HHR Roundtable and Community of Interest work is aligned with HealthForceOntario's Inter-professional Care Blueprint.

There has been progress in building a knowledge economy in the Northwest, and health care is recognized as a key driver in this transition.

Priority related MLAA Indicators:

Rates of ED Visits that could be managed elsewhere.

Regional Health Human Resources Multi-Year Plan

Proposed Strategies	Critical Partnerships	Timelines			Outcomes
		2008/ 2009	2009/ 2010	2010/ 2011	
Support innovative strategies for health care providers to work at their full scope of practice.	▪ HSPs ▪ HFO ▪ HHR Roundtable ▪ Community of Interest ▪ MOHLTC ▪ HPAC (Health Professionals Advisory Committee)				▪ Enhanced knowledge/understanding of scope of practice potential in the North West LHIN (e.g. best practices and opportunities). ▪ The initial point of contact for primary care may be with a non-physician provider, and will improve access to primary care. ▪ Clients are seen by the most appropriate provider as they enter the health system and throughout their care, increasing the availability of primary care physicians for cases requiring their scope of practice. ▪ Job satisfaction amongst providers working to their full scope is increased and retention is improved.
LHIN linkages with academic health sciences groups and providers will be maintained and enhanced to explore opportunities, gaps, skills and educational issues, in alignment with the work of HFO.	▪ HFO ▪ HSPs ▪ MOHLTC ▪ Lakehead University				▪ Educational programs for health professionals will be better aligned with the needs of employers and HFO strategic direction. ▪ Number of collaborative

	▪ Confederation College ▪ Northern Ontario School of Medicine ▪ The Michener Institute				educational/knowledge transfer activities between LHIN and partners will be increased. ▪ Employment of students by the LHIN for research activities will continue. ▪ Collaboration between LHIN and partners for completion of research will be increased.
Continue to work with HealthForceOntario: ▪ in monitoring ED Physician Coverage across the LHIN; and ▪ on the Regional Group Locum Program.	▪ HFO ▪ Thunder Bay Regional Health Sciences Centre ▪ Dryden Regional Health Centre ▪ Lake of the Woods District Hospital ▪ Riverside Healthcare Facility Inc.				▪ Timely reporting of ED Physician Coverage. ▪ Collaboration between LHIN and partners to address ED physician coverage. ▪ Common credentialing program in place for all partners.
Continue to pursue the development and implementation of the e-Health initiative as this has a positive effect on access to primary care services. This should include: ▪ EHR; ▪ e-Physician; ▪ e-Pharmacist; and	▪ FHTs ▪ Physicians ▪ HHR Roundtable ▪ e-Health Advisory Team ▪ Communities of Interest				▪ Improved communication regarding the health status of clients will reduce duplication and improve quality of care. ▪ More effective and efficient use of existing primary care providers will increase access for clients.

▪ Enhanced telemedicine capacity and opportunities. ▪	▪ HSPs ▪ Ontario Telemedicine Network (OTN)				
Champion inter-professional learning and practice.	▪ Academic Health Programs ▪ FHTs ▪ CHCs ▪ HFO ▪ HSPs ▪ HPAC				▪ HSPs will have increased involvement with innovative HFO programs. ▪ Clinicians will be better prepared to work as practice teams. ▪ There will be an increase in the number of services provided by inter-professional teams. ▪ Extensive knowledge transfer re: true inter-professional education and practice will occur.
Identify HHR challenges/shortages/ opportunities on an ongoing basis.	▪ HSPs ▪ HHR Roundtable ▪ Community of Interest ▪ HPAC ▪ Emergency Department Lead ▪ Critical Care Lead				▪ Identification of HHR needs and opportunities for collaboration/integration. ▪ Valid data for decision-making and risk management.

4.0 LHIN Operations Financial Summary and Transfer Payments Allocation Plan

Table 1 represents the LHIN's staffing plan and the number of projected Full Time Equivalents (FTE's) based on information available at the time of writing.

Table 1: LHIN Staffing Plan

	2007/08 Actuals as of March 31, 2008	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan
Number of FTE	22	27	27	27	27

Position Title:
Chief Executive Officer
Senior Director - Planning, Integration and Community Engagement
Senior Director - Performance, Contract and Allocation
Controller/Business Support Manager
Senior Consultant, Planning and Community Engagement
Senior Consultant, Planning and Integration
Senior Consultant, Funding and Allocation
Senior Consultant, Funding Performance & Contract Management
Senior Consultant, Performance & Contract Management
Executive Assistant to the CEO
Program Assistant
Receptionist
Senior Integration Consultant
Program Assistant
Communications Specialist
Administrative Assistant
Executive Assistant
Senior Consultant Planning and Integration
Senior Consultant Performance and Integration
Epidemiologist/Decision Support Consultant
Financial Analyst
Senior Aboriginal Planning & Community Engagement Consultant
Funding & Performance Consultant - 2
Aboriginal Planning & Community Engagement Consultant
Planning and Integration Consultant - 2

Table 2 provides the spending plan for the North West LHIN. The 2008/09 plan is based on the allocation provided by the Ministry of Health and Long-Term Care. The plans for the years 2009/10 and beyond are the North West LHIN's best estimate as the allocation for those years has not yet been provided to the LHIN.

Table 2: LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2007/08 Actuals	2008/09 Allocation	2009/10 Planned Expenses	2010/11 Planned Expenses	2011/12 Planned Expenses
Salaries and Wages	1,726,867	2,485,000	2,609,250	2,739,713	2,876,698
Employee Benefits					
HOOPP	170,390	248,500	260,925	273,971	287,670
Other Benefits	171,625	271,500	285,075	299,329	314,295
Total Employee Benefits	***342,015***	***520,000***	***546,000***	***573,300***	***601,965***
Transportation and Communication					
Travel expenses	224,032	290,000	295,800	301,716	307,750
Governance Travel	76,758	82,000	83,640	85,313	87,019
Communications	73,534	90,000	91,800	93,636	95,509
Total Transportation and Communication	***374,324***	***462,000***	***471,240***	***480,665***	***490,278***
Services					
Accommodation & Insurance	197,374	219,000	223,380	227,848	232,405
Advertising	19,789	30,000	30,600	31,212	31,836
Aboriginal Community Engagement	118,442	160,000	163,200	166,464	169,793
Consulting Fees	217,148	300,000	306,000	312,120	318,362
Governance Per Diems	121,775	130,000	132,600	135,252	137,957
Professional fees – Audit	14,000	14,600	14,892	15,190	15,494
LSSO Shared Costs	300,000	300,000	306,000	312,120	318,362
Other Meeting Expenses	69,352	65,000	66,300	67,626	68,979
Other Governance Costs	29,065	34,000	34,680	35,374	36,081
Printing & Translation	39,144	45,000	45,900	46,818	47,754

Staff Development & Recruitment	155,928	140,000	142,800	145,656	148,569
Total Services	***1,282,017***	***1,437,600***	***1,466,352***	***1,495,679***	***1,525,593***
Supplies and Equipment					
IT Equipment	29,180	35,000	35,700	36,414	37,142
Office Supplies & Purchased Equipment	84,935	80,000	81,600	83,232	84,897
Total Supplies and Equipment	***114,115***	***115,000***	***117,300***	***119,646***	***122,039***
Capital Expenditures	***33,769***	***20,000***	***20,000***	***20,000***	***20,000***
LHIN Operations: Total Planned Expense	3,839,338	5,019,600	5,210,142	5,409,002	5,616,573

The following schedule is the projected transfer payment funding by sector. The schedule reflects targets for planning purposes as of May 16, 2008 and actual transfer payments may vary.

Total Health Service Provider (HSP) Transfer Payments by Sector:	**2008/09 Funding Allocation (000's)**	**2009/10 Funding target (000's)**	**2010/11 Funding target (000's)**
Operation of Hospitals	379,525.0	380,008.2	380,008.2
Grants to compensate for Municipal Taxation - public hospitals	104.3	104.3	104.3
Long Term Care Homes	55,033.1	55,033.1	55,033.1
Community Care Access Centres	34,705.7	36,093.9	37,898.6
Community Support Services	10,141.7	10,369.9	10,603.2
Acquired Brain Injury	1,025.2	1,048.2	1,071.8
Assisted Living Services in Supportive Housing	4,174.9	4,268.8	4,364.9
Community Health Centres	6,553.3	6,553.3	6,553.3
Community Mental Health	28,700.4	29,346.1	30,006.4
Addictions Program	11,455.4	11,713.1	11,976.7
Initiatives	2,986.2	3,790.3	5,265.1
Total:	**534,405.2**	**538,329.2**	**542,885.6**

5.0 Risk Summary

Hospital Service Accountability Agreements (H-SAAs)

The Local Health System Integration Act, 2006 (LHSIA) requires LHINs to enter into Service Accountability Agreements (H-SAAs) with hospitals by March 31, 2008.

At this time, two hospitals remain outstanding and have not signed an H-SAA. The North West LHIN has started a process under Section 23 of the Commitment to the Future of Medicare Act (CFMA) directing the two hospitals to enter into an agreement. In both cases, the hospitals have indicated they are unable to meet the terms and conditions of the H-SAA relating to the requirement for a balanced budget. The North West LHIN will continue to meet with the hospitals to negotiate an acceptable accountability agreement within available funding.

Service Accountability Agreements (SAAs) with Community Health Service Providers

LHSIA requires LHINs to enter into Service Accountability Agreements (SAAs) with community health service providers (HSPs), other than long-term care homes, by March 31, 2009.

The concept of SAAs is new to all community health sectors. The LHIN will work with the HSPs to ensure they understand the benefits of a service accountability agreement to the health system and the people they serve.

Centre of Excellence for Integrated Seniors' Services

In 2007, the Centre of Excellence for Integrated Seniors' Services (CEISS) was announced. This project realigns and expands various existing health services to provide clients with access to more appropriate community and long-term care services. The project concept was agreed upon by the multiple parties involved including the MOHLTC, Ministry of Municipal Affairs and Housing, North West LHIN, City of Thunder Bay, the North West CCAC, CSS agencies and St. Joseph's Care Group. The viability of the CEISS project hinges on finalizing the architectural design, capital cost estimate and tendering process, project management and construction phases. A project team has been established, led by SJCG, which is responsible to ensure the project moves forward within budget.

The LHIN will continue to work with the MOHLTC, Ministry of Housing, SJCG and the City of Thunder Bay on the development and implementation of the Centre of Excellence for Integrated Seniors' Services.

Northern Information and Communication Technology Blueprint

The North West LHIN is working with the North East LHIN and many of our health service providers toward implementing a Northern Information and Communications Technology (ICT) Blueprint. Aligning with the Ministry's e-Health initiative, the Blueprint incorporates the needs of the northern health system toward improving patient care, access, flow and safety. This strategy is a key enabler of many North West LHIN IHSP priorities and is critical to advancing them. Initial cost estimates indicate implementation of these strategies could be substantial.

The North West LHIN will continue to work with the North East LHIN and the Region's HSPs on the implementation of the Blueprint. The e-Health Advisory Team will help establish priorities for the group and provide recommendations regarding how to proceed.

HSP Service Pressures

Some health service providers in the Northwest have indicated that they have service pressures which exceed their financial capacity and that issues arising out of budgeting processes will be difficult to address based on their funding allocation.

The North West LHIN will monitor the financial and service delivery activities of HSPs to ensure they balance their operations. Where financial or service delivery pressures exist, the LHIN will request that HSPs develop risk mitigation strategies to ensure health services are maintained and pressures are minimized. The LHIN will be looking to HSPs to develop integration opportunities and lever the existing resources available to maximize the efficiency and effectiveness of the local health system. The North West LHIN will also utilize its available discretionary funding, including urgent priorities funding, to make strategic investments in client services based on the North West LHINs Priority Setting Framework and its Integrated Health Services Plan.

Health Human Resource Pressures

The HSPs in the North West LHIN have experienced difficulties with recruiting and retaining most health professionals. This has provided service delivery challenges for these HSPs.

The North West LHIN has created a Health Human Resources Roundtable and a Health Professional Advisory Committee (HPAC) to advise the LHIN with its Health Human Resources (HHR) planning and strategies. The North West LHIN is aligned with HealthForceOntario which has the responsibility for recruitment and retention in Ontario. In addition, the LHIN has explored and supported innovative models of practice such as videoconferencing and mobile health units.

Northwest Economy and Demographic Profile

The economic, cultural, geographic and demographic diversity of the Northwest will challenge the LHIN over this planning period. Issues include:

- the economic downturn which is expected to continue to affect the recruitment and retention of all HHR;
- the difficulty experienced by smaller HSPs to achieve economies of scale due to a widely dispersed population over a large geographic area;
- limited services in smaller communities result in increased resource pressures on the larger communities and larger HSPs; and
- the demographic profile of Northwest residents indicates significant chronic disease rates and lower health status than the rest of the province which, influences service type, service delivery and availability of resources.

The North West LHIN will strive to mitigate the affects of the above factors by implementing the strategies outlined in the IHSP.

Alternate Level of Care

Alternate Level of Care (ALC) is a significant issue throughout the North West LHIN, but particularly in Thunder Bay.

The North West LHIN has recently approved the addition of five interim long-term care beds in the City of Thunder Bay to help alleviate some of the hospitals pressures. In addition, the LHIN is continuing to work towards a longer term solution with various parties. The North West LHIN continues to participate with acute care and community-based HSPs to develop innovative solutions.